THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 2, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your letter regarding how we can ensure that employers are able to navigate the Affordable Care Act and understand how the law affects them and their employees.

The Department of Health and Human Services (HHS) is working closely with the Departments of Labor (DOL) and the Treasury as well as the Small Business Administration (SBA) to ensure that consumers and small businesses have the information they need to make informed decisions about their insurance coverage options. We are currently enhancing our online Affordable Care Act resource for consumers, Healthcare.gov, and plan to relaunch it in June of this year. This website already contains information useful for employers, but our goal with the relaunch is to have a more robust section focused on small businesses and the Small Business Health Options Program (SHOP).

The DOL, Internal Revenue Service (IRS), and SBA also have useful Affordable Care Act information on their websites, DOL.gov/ebsa/healthreform/, IRS.gov/aca, and SBA.gov/healthcare, respectively. DOL maintains a dedicated Affordable Care Act website with regulatory guidance and other useful information for employers. The IRS is working to make improvements to its Affordable Care Act content to make the information more user-friendly for individuals and employers, and it plans to relaunch this portion of its website soon. Similarly, the SBA website has been developed specifically for the self-employed and small employer audience with content segmented by employer size, and the SBA is continually updating and improving upon its content so businesses can quickly filter and find the information they need.

In your letter, you ask for a one-stop resource for employers that has an Affordable Care Act employer toolkit, glossary of terms, compliance timeline, examples of employer scenarios, affordability calculator, as well as the various guidance documents and regulations that pertain to employers, and summaries thereof. We agree that a comprehensive website for employers that provides critical information about how the Affordable Care Act impacts businesses and their employees and families is needed. Specifically, we believe the SBA website, with its focus on information for those businesses with fewer than 500 employees, can serve as an entry point for employer information prepared by the HHS, DOL, and IRS websites.

Currently, the SBA website already provides information related to employer size, links to a Glossary of Key Health Care Reform Terms, and an interactive timeline of the key Affordable Care Act insurance reforms, and it features training materials (including a PowerPoint presentation and fact sheets about what the health care law means for businesses). Our SBA colleagues are committed to providing small businesses with all of the tools and resources they need to understand what the health care law means for them. They are working with us as well as IRS and other federal agencies to ensure their website can serve as a one-stop resource for small businesses.

We intend to promote the SBA website as a key resource for the self-employed and small business owners. At the same time, we are consolidating the employer-related content on each of the other websites to ensure that the employer community can easily and quickly get the information they need regardless of which website they use.

HHS and SBA representatives are also working together around the country to give in-person presentations to chambers of commerce, business groups, and other relevant stakeholders who have a commitment to ensuring that employers have the information and tools they need to navigate the health care law. In addition to our web presence, we are committed to business outreach as an essential component of the Marketplace education and outreach strategy.

We share your commitment to supporting employers as they work to implement the Affordable Care Act. I appreciate your input and support as we continue to develop resources to ensure businesses of all sizes have the information they need to successfully implement the law and help give millions more Americans access to affordable health insurance coverage.

Again, thank you for your letter. I appreciate your leadership on this and other issues related to health care reform, and I look forward to working with you as we continue to implement the Affordable Care Act. Please do not hesitate to contact me with any further thoughts or concerns.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 11, 2013

The Honorable Barbara Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chair:

Thank you for your invitation to testify at the February 14 Appropriations Committee hearing regarding the impact of sequestration. Regretfully, I am unable to be with you on Thursday. As you know, I will be in Chicago for a two day visit that has been planned for some time, to highlight the benefits of the Affordable Care Act and ongoing work related to implementation. I will be doing events with Governor Quinn, Mayor Emanuel, meeting with the editorial board of the newspaper, as well as leaders of multiple large organizations to build the vital partnerships needed to ensure individuals and families without health insurance can enroll in Medicaid and the Exchanges. Illinois has a large uninsured population, and we are reliant on outreach and education efforts to ensure middle class families and our most vulnerable citizens can benefit from the expansion of coverage made possible by the Affordable Care Act.

I appreciate your focus on the devastating impact sequestration would have on the Department's mission and the populations it serves. I remain hopeful that the Administration and Congress can work together to avoid the dire consequences for the American people that would result from sequestration.

Sincerely,

Kathleen

Kathleen Sebelius

I am very eager to work with you in your new capacity.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 1, 2013

The Honorable Barbara Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Chairwoman Mikulski:

Thank you for your letter regarding the automatic, across-the-board spending cuts set to occur on March 1, 2013. I share your concerns about the potential consequences of these cuts on the critical social service, public health and scientific research, and health care coverage and oversight programs administered by the Department of Health and Human Services (HHS). As the examples below illustrate, our efforts to protect the health and enhance the well-being of all Americans, as well as our commitments to grantees, contractors, and state and local governments, would be significantly impacted by the potential sequester.

Social Services

Sequestration would hinder the Department's work to support American children and families. For example, up to 70,000 children would lose access to Head Start and Early Head Start services. This impact would be felt across the nation, with community and faith-based organizations, small businesses, local governments, and school systems laying-off over 14,000 teachers, teacher assistants, and other staff. Services for children and families would be disrupted, with some Head Start centers needing to close their classrooms early this school year or reopen their programs late in the fall. Programs would have to cut services, staff, and classrooms for the 2013-2014 school year. In addition, sequestration would further impact our ability to help families succeed by leaving up to 30,000 children without child care services. Without a safe and secure environment for their children, working parents would have a difficult time seeking or keeping employment.

Sequestration could compromise the health and well-being of more than 373,000 seriously mentally ill adults and seriously emotionally disturbed children who potentially would not receive needed mental health services, which could result in increased hospitalizations and homelessness. In addition, we expect that 8,900 homeless persons with serious mental illness might not receive the vital outreach, treatment and housing, and supports that they need to help in their recovery process. Admissions to inpatient facilities for people in need of critical addiction services could be reduced by 109,000, and almost 91,000 fewer people could receive substance abuse treatment services.

Our nation's seniors would also feel the impacts of sequestration. In particular, congregate and home-delivered nutrition services programs would serve 4 million fewer meals to seniors.

The cuts required by sequestration could slow efforts to improve the delivery of health care to American Indians and Alaska Natives through the Indian Health Service (IHS) and would result in about 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits provided in IHS and Tribal hospitals and clinics. IHS may lack resources to pay for the staffing and operations of five health care facilities that tribes have built with their own resources, with a total tribal investment of almost $200 million.

Sequestration would impair the Department's ability to prevent and treat HIV/AIDS. The cuts to the Centers for Disease Control and Prevention (CDC) translate into approximately 424,000 fewer HIV tests conducted by CDC's health department grantees. The Health Resources and Services Administration estimates that 7,400 fewer patients would have access to life-saving HIV medications through the AIDS Drug Assistance Program (ADAP). This would cause delays in service and drug provision to people living with HIV and potentially lead to ADAP wait lists for HIV medications.

Public Health and Scientific Research

Reduced funding for the Food and Drug Administration (FDA), including user fees, could increase risks to our nation's food safety. FDA would conduct approximately 2,100 fewer domestic and foreign facility inspections of firms that manufacture food products to verify that domestic and imported foods meet safety standards. These reductions may increase the risk of safety incidents, and the public may suffer more foodborne illness such as the recent salmonella in peanut butter outbreak and the E. coli illnesses linked to organic spinach.

Cuts to the National Institutes of Health (NIH) due to sequestration would delay progress on the prevention of debilitating chronic conditions that are also costly to society and on the development of more effective treatments for common and rare diseases affecting millions of Americans. In general, NIH grant funding within states, including Maryland, will likely be reduced due to both reductions to existing grants and fewer new grants. We expect that some existing research projects could be difficult to pursue at reduced levels and some new research could be postponed as NIH would make hundreds fewer awards. Actual funding reductions will depend on the final mix of projects chosen to be supported by each Institute and Center within available resources. With each research award supporting up to seven research positions, several thousand research positions across the nation could be eliminated.

Health Care Coverage and Oversight

Under sequestration, payments to Medicare providers, health plans, and drug plans under Title XVIII of the Social Security Act will be reduced by two percent. This would result in billions of dollars in lost revenues to Medicare doctors, hospitals, and other providers, who will only be reimbursed at 98 cents on the dollar for their services to Medicare beneficiaries.

Sequestration would limit the Department's ability to realize savings produced through proven investments, such as the Health Care Fraud and Abuse Control program. For every dollar spent to combat health care fraud through our law enforcement work we have realized an over $7 return on investment. In FY 2011 alone, we returned a record-breaking $4.1 billion to the federal government.

I am eager to work with you and Congress to avoid the consequences that would result from sequestration. Thank you for your interest in this important issue.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 28, 2013

The Honorable John Kline
Chairman
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter requesting a status report on the three reports to Congress mandated in the 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). Unfortunately, we were too ambitious in our last update in which we stated that we hoped to have all three reports to you by December 2012. I am sorry we were unable to meet the projected deadline.

I am, however, pleased to inform you that two of the reports about which you inquired, *Effectiveness of State CAPTA Programs and Technical Assistance* and *Interagency Coordination Efforts in Child Abuse and Neglect,* are nearing completion. The third report, *A Study on Immunity from Prosecution Laws for Professional Consultation in Suspected Cases of Child Abuse and Neglect*, was unavoidably delayed due to contractual issues, which have since been resolved. The study is nearly completed, and the drafting of the report is underway.

As requested in your letter, staff from my Department met with your staff on February 6, 2013, to discuss the status of all three CAPTA reports. In the briefing, my staff explained the Department's clearance process and agreed to keep your staff informed as to the progression of all three reports.

We continue to work diligently to finalize the first two reports and to complete the drafting of the third report. Please know that I share your desire to release these reports, and we are making every effort to move them along as expeditiously as possible.

I look forward to continuing to work with you on issues related to CAPTA. I will also provide this response to Representative Miller.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 28, 2013

The Honorable George Miller
Ranking Member
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Miller:

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Sincerely,

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 1, 2013

The Honorable Barbara Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Chairwoman Mikulski:

Thank you for your letter regarding the automatic, across-the-board spending cuts set to occur on March 1, 2013. I share your concerns about the potential consequences of these cuts on the critical social service, public health and scientific research, and health care coverage and oversight programs administered by the Department of Health and Human Services (HHS). As the examples below illustrate, our efforts to protect the health and enhance the well-being of all Americans, as well as our commitments to grantees, contractors, and state and local governments, would be significantly impacted by the potential sequester.

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I am eager to work with you and Congress to avoid the consequences that would result from sequestration. Thank you for your interest in this important issue.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 20, 2012

The Honorable Dave Camp
Chairman, Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter inquiring about the status of the Indicators of Welfare Dependence Report. As you know, the Welfare Indicators Act of 1994 directed my Department to produce annual reports about the extent to which families depend on income and benefits from Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), and Supplemental Security Income (SSI). The reports also include information on factors indicating a person's risk for becoming dependent – including one's degree of economic security, employment and barriers to employment, and non-marital childbearing.

The 2008 Welfare Indicators Report provided welfare dependence indicators and risk factors through 2005, reflecting changes that have taken place since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Since that report was produced, we have experienced several unforeseeable challenges that have contributed to a delay in producing the next Welfare Indicators Report. These include a combination of programming issues, methodological challenges, and efforts to improve the data and its presentation. I am enclosing an attachment that describes these challenges in more detail, as well as improvements we are making to enhance the quality of the next report.

We currently have data for all but one of the 33 indicators that are presented in the Welfare Indicators Report. Following a thorough review and an extensive data verification process, we expect the twelfth edition of Indicators of Welfare Dependence to be completed in time for submission within the first 60 days of the regular session of Congress, as required by 42 U.S.C. 1314a(d)(4). In the meantime, we would be happy to provide a staff-level briefing or provide information on specific indicators as they are available.

Thank you very much for your letter and your interest in the Welfare Indicators Report. We are committed to the production of high-quality data. We believe that the upcoming report will be a significantly improved product that helps to increase the understanding of the indicators and

predictors of welfare dependence. I also will share this response with the other members of Congress who cosigned your letter.

Sincerely,

Kathleen Sebelius

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 20, 2012

The Honorable John Kline
Chairman, Committee on Education and the Workforce
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter inquiring about the status of the Indicators of Welfare Dependence Report. As you know, the Welfare Indicators Act of 1994 directed my Department to produce annual reports s about the extent to which families depend on income and benefits from Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and Supplemental Security Income (SSI). The reports also include information on factors indicating a person's risk for becoming dependent – including one's degree of economic security, employment and barriers to employment, and non-marital childbearing.

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Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 20, 2012

The Honorable Frank Lucas
Chairman, Committee on Agriculture
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter inquiring about the status of the Indicators of Welfare Dependence Report. As you know, the Welfare Indicators Act of 1994 directed my Department to produce annual reports s about the extent to which families depend on income and benefits from Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and Supplemental Security Income (SSI). The reports also include information on factors indicating a person's risk for becoming dependent – including one's degree of economic security, employment and barriers to employment, and non-marital childbearing.

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Sincerely,

Kathleen Sebelius

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 20, 2012

The Honorable Fred Upton
Chairman, Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter inquiring about the status of the Indicators of Welfare Dependence Report. As you know, the Welfare Indicators Act of 1994 directed my Department to produce annual reports s about the extent to which families depend on income and benefits from Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and Supplemental Security Income (SSI). The reports also include information on factors indicating a person's risk for becoming dependent – including one's degree of economic security, employment and barriers to employment, and non-marital childbearing.

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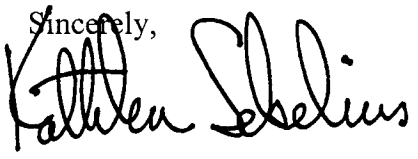

Kathleen Sebelius

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 20, 2012

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
United States Senate
Washington, D.C. 20510

Dear Senator Hatch:

Thank you for your letter inquiring about the status of the Indicators of Welfare Dependence Report. As you know, the Welfare Indicators Act of 1994 directed my Department to produce annual reports s about the extent to which families depend on income and benefits from Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and Supplemental Security Income (SSI). The reports also include information on factors indicating a person's risk for becoming dependent – including one's degree of economic security, employment and barriers to employment, and non-marital childbearing.

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Sincerely,

Kathleen Sebelius

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 20, 2012

The Honorable Michael Enzi
Ranking Member
Health, Education, Labor and Pensions Committee
United States Senate
Washington, D.C. 20510

Dear Senator Enzi:

Thank you for your letter inquiring about the status of the Indicators of Welfare Dependence Report. As you know, the Welfare Indicators Act of 1994 directed my Department to produce annual reports s about the extent to which families depend on income and benefits from Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and Supplemental Security Income (SSI). The reports also include information on factors indicating a person's risk for becoming dependent – including one's degree of economic security, employment and barriers to employment, and non-marital childbearing.

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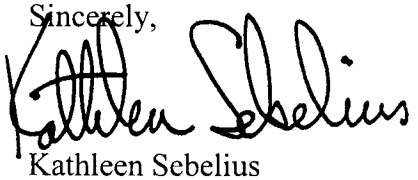

Kathleen Sebelius

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 20, 2012

The Honorable Pat Roberts
Ranking Member
Agriculture, Nutrition and Forestry Committee
United States Senate
Washington, D.C. 20510

Thank you for your letter inquiring about the status of the Indicators of Welfare Dependence Report. As you know, the Welfare Indicators Act of 1994 directed my Department to produce annual reports s about the extent to which families depend on income and benefits from Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and Supplemental Security Income (SSI). The reports also include information on factors indicating a person's risk for becoming dependent – including one's degree of economic security, employment and barriers to employment, and non-marital childbearing.

The 2008 Welfare Indicators Report provided welfare dependence indicators and risk factors through 2005, reflecting changes that have taken place since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Since that report was produced, we have experienced several unforeseeable challenges that have contributed to a delay in producing the next Welfare Indicators Report. These include a combination of programming issues, methodological challenges, and efforts to improve the data and its presentation. I am enclosing an attachment that describes these challenges in more detail, as well as improvements we are making to enhance the quality of the next report.

We currently have data for all but one of the 33 indicators that are presented in the Welfare Indicators Report. Following a thorough review and an extensive data verification process, we expect the twelfth edition of Indicators of Welfare Dependence to be completed in time for submission within the first 60 days of the regular session of Congress, as required by 42 U.S.C. 1314a(d)(4). In the meantime, we would be happy to provide a staff-level briefing or provide information on specific indicators as they are available.

Thank you very much for your letter and your interest in the Welfare Indicators Report. We are committed to the production of high-quality data. We believe that the upcoming report will be a significantly improved product that helps to increase the understanding of the indicators and

predictors of welfare dependence. I also will share this response with the other members of Congress who cosigned your letter.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosure

Welfare Indicators Report:
Production Challenges and Improvements

The Welfare Indicators Report presents data on the rate of welfare dependence, the degree and duration of welfare receipt and dependence, and predictors of welfare dependence. Given data limitations, for purposes of the Welfare Indicators Report we define "welfare dependence" as the proportion of all individuals in families who receive more than half of their total family income in one year from TANF, SNAP, or SSI.

The report also includes information on a larger set of risk factors associated with receiving welfare. The risk factor indicators supplement the dependence indicators to ensure that dependence measures are not assessed in isolation. The risk factors cover three broad categories – economic security, employment and barriers to employment, and non-marital childbearing. The economic security risk factors include measures of poverty and well-being that are important as potential predictors of dependence. The employment and barriers to employment measures include data on overall labor force attachment and employment and earnings for low-skilled workers, as well as data on barriers to work. The non-marital childbearing risk factors include data on long-term time trends in non-marital births, since children living in families with mothers who have never been married are more likely to become dependent as adults.

Research staff working on the Welfare Indicators Report experienced a combination of programming issues and methodological challenges in producing the twelfth report, as follows:

- A change in programming staff resulted in the need to completely re-construct the data and programming code for several indicators to enable replication of prior results in order to ensure a consistent baseline from which to measure changes.

- The Welfare Indicators Report uses data from the Current Population Survey, the Survey of Income and Program Participation, and the Panel Study of Income Dynamics, as well as data from the Bureau of Labor Statistics, the National Center for Health Statistics, and administrative data for the TANF, SNAP, and SSI programs. These data are produced on different schedules, some of which are not produced annually. In addition, some indicators require special tabulations of internal data that are separate from public-use data releases, which requires additional work on the part of the above agencies.

As efforts to address these challenges were underway, research staff took a series of additional steps to improve the data and its presentation, as follows:

- Previous editions of the Welfare Indicators Report have not included data updates for all indicators, and the time periods varied across some indicators, owing to the different data sources and schedules for release. The upcoming Welfare Indicators Report will include updated data for 2006-2009 for nearly all of the indicators.

- The nature of the Welfare Indicators Report has evolved over the years from a mere compendium of data series from a variety of sources to a more unified report with improved consistency and uniformity in methodology. For example, efforts are being made to provide greater standardization in age breaks for persons ages 18-64 for as many indicators as possible.

- Staff also have been working to reconstruct every chart and figure in the report and to standardize the graphics to make them more stable for web presentation.

- The upcoming edition of the Welfare Indicators Report will include some state level data to support the national data that has always been presented.

While these changes have contributed to additional production time, they will contribute to an improved understanding of the indicators and predictors of welfare dependence.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 11, 2012

The Honorable Herbert Kohl
Chairman
Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for acknowledging the anniversary of the Nursing Home Reform Initiative as well as our accomplishments with regard to Home & Community Based Waiver programs. Supporting the quality of care provided in nursing homes is a priority for the Centers for Medicare & Medicaid Services (CMS). We appreciate the importance that individuals place on small and community-integrated environments, such as the Green House homes that you describe in your letter.

Your letter raises several issues regarding the operation of this type of nursing home model, including the ability to certify multiple nursing home sites under a single provider agreement, and, if possible, the conditions under which such a provider organization could be certified to participate in the Medicare and Medicaid programs. Earlier this year, CMS staff met with Mr. Robert Jenkens, Director of the Green House Project. I understand that the Green House Project has begun to analyze whether St. John's Homes can increase the number of homes certified under New York law under a single provider number with the St. John's main campus. We look forward to their review. In addition, we have been working with our legal counsel to review the legal and policy issues relevant to the question of whether community integrated small house models may be certified under Medicare as a single provider. We will advise you of the results of our evaluation.

Thank you for bringing this matter to my attention. We look forward to discussing strategies for moving community embedded small houses forward and continuing to improve long-term care services and supports.

Sincerely,

Kathleen Sebelius

Thank you for your service – & the elderly, to help pass health reform, & my sister & her family. It has been my honor to work with you.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

August 24, 2012

The Honorable John Kline
Chairman
Committee on Education and the Workforce
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter expressing concern about reports to Congress required under the Child Abuse Prevention and Treatment Act (CAPTA) Reauthorization Act of 2010. I appreciate your concern and agree that these topics will contribute to our knowledge base and to moving the child abuse prevention policy forward.

Unfortunately, no funds have been specifically appropriated to complete these studies, which are resource-intensive endeavors. Given these resource limitations, we are working diligently to complete the reports as quickly as possible.

The three reports you inquired about are: *Effectiveness of State CAPTA Programs and Technical Assistance; Interagency Coordination Efforts in Child Abuse and Neglect;* and *Study on Immunity from Prosecution Laws for Professional Consultation in Suspected Cases of Child Abuse and Neglect.* These reports are all currently under development. We hope that they will be ready to submit to the committee by the end of December 2012.

I look forward to continuing to work with you on issues related to CAPTA. I will also provide this response to Representative Miller.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

August 24, 2012

The Honorable George Miller
Ranking Member
Committee on Education and the Workforce
United States House of Representatives
Washington, DC 20515

Dear Representative Miller:

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I look forward to continuing to work with you on issues related to CAPTA. I will also provide this response to Representative Kline.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

October 4, 2012

The Honorable Sam Graves
Chairman
Committee on Small Business
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Graves:

Thank you for your letter regarding the Affordable Care Act and how it will affect small businesses. The President asked me to respond on his behalf. I appreciate that you took the time to provide your thoughts on this important issue.

The Affordable Care Act assists small businesses by providing health care tax credits to defray the cost of providing employee health insurance. Many small businesses are eligible for tax credits up to 35 percent of their business' share of employees' premiums. Starting in 2014, the value of the credit increases to 50 percent for qualifying businesses, and both individuals and small businesses will be able to purchase private health insurance through state-based competitive marketplaces called Affordable Insurance Exchanges. With respect to the "Shared Responsibility" provision beginning in 2014, small businesses that have fewer than 50 employees – roughly 96 percent of all small businesses in the United States – are exempted from the employer responsibility requirement. For those businesses that are subject to the law, the penalty, if applicable, is not applied to the first 30 full time employees.

Starting in 2014, Exchanges will operate a Small Business Health Options Program (SHOP) that offers small businesses and their employees new choices. Through SHOP, employers can offer employees a variety of Qualified Health Plans (QHPs), and employers and employees can choose the plans that best fit their needs and their budgets. SHOP will reduce the administrative burden and costs of enrolling employees in small group plans while offering small employers many of the choices that large businesses already enjoy. SHOP will do the work of finding QHPs, getting information on price and benefits, enrolling eligible employees, and consolidating billing.
You also expressed concern about regulatory burden, pointing out that a number of provisions in the law affect small businesses. By law, the Department of Health and Human Services must assess the burden of any proposed regulation. The impact on small businesses of a proposed regulation is carefully assessed. Minimizing regulatory burden to the greatest extent possible, consistent with implementing the law, is a high priority for the Department.

Since the passage of the Affordable Care Act, national health spending is rising at a slower rate, health insurance premiums are rising at a slower rate, small business coverage is holding steady, and Medicare is on stronger financial footing. I look forward to working with you to ensure that small businesses and their employees continue to benefit from the law. Please do not hesitate to contact me if you have any further thoughts or concerns.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

July 23, 2012

The Honorable Robert P. Casey, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Casey:

This is a follow-up to my April 20, 2012, response to you regarding your request that my Department conduct a study on the mandated reporting of child abuse and neglect under the Child Abuse Prevention and Treatment Act. In your letter you specified three main topics to be addressed, with specific questions under each topic. The topics are: the requirement in 18 states that all adults report suspected or witnessed child abuse; legal standards in states for training of mandated reporters; and state definitions of child abuse that do not include deliberate acts by any individual that lead to death, serious harm, or imminent risk of serious harm.

Many of your questions could be addressed via existing mechanisms, most notably analyses of data from our National Child Abuse and Neglect Data System, our Child Welfare Information Gateway, and the Children's Bureau, which is my Department's program office that has primary responsibility for child protection and child welfare.

Responses to your questions are organized by topic in the attached enclosure and the appendices to the enclosure. I hope that the analyses and information presented here provide a greater insight into the differences and similarities among the states. Thank you again for your interest in improving our nation's ability to prevent and respond to child abuse.

Sincerely,

Kathleen Sebelius

Enclosures

Responses to Senator Casey's Questions about Mandatory Reporting of Child Abuse and Neglect

Topic I. State requirement that all adults report suspected or witnessed child abuse

Eighteen states require all adults to report suspected or witnessed child abuse. The number of states was determined by reviewing a document on the Child Welfare Information Gateway, titled *Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws.*[1] According to the document, 18 states and the Commonwealth of Puerto Rico require any person to report suspected child abuse or neglect. These states, known as mandated reporting states, are: Delaware, Florida, Idaho, Indiana, Kentucky, Maryland, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, and Wyoming.

The remaining 32 states and the District of Columbia are referred to in the Gateway document as permissive reporting states. In permissive reporting states, any individual may report abuse and neglect, but not everyone is required to report maltreatment. In addition, a review of state statutes indicates that all permissive reporting states and many mandatory reporting states do list specific mandated reporters, e.g., teachers, day care providers, pediatricians, etc.[2]

Have these (mandated reporting) states seen improved rates of substantiated child abuse? How have they handled the increase in reports, and have they been able to accommodate the increase in reporting without sacrificing their ability to respond to reports?

Many state-mandated reporter laws have been in place for quite some time. Therefore, the Children's Bureau in the Administration for Children and Families (ACF) is unable to compare and contrast the differences before and after such laws were enacted. However, a data analysis was performed for years 2006–2010, and the rates of disposition and victimization for both mandated and permissive reporting states were compared.[3] Figure 1 in Appendix A provides state disposition and victimization rates from 2006 to 2010.

The disposition rate is the rate per 1,000 children in the population who received a Child Protective Services (CPS) response in the form of an investigation response or alternative response. While the disposition rates have fluctuated during the past five years for both mandated and permissive states, the disposition rates for the mandated states have been consistently higher than the rates for permissive states. For example, in 2010 nearly 46

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[1] The Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws is available at: http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm. This is an introduction to the State Statute Series section on mandatory reporters.

[2] Go to: http://www.childwelfare.gov/systemwide/laws_policies/state/

[3] 2010 is the most recent data available from NCANDS.

children (45.9) per 1,000 children in the population received a CPS response in mandated reporting states, while nearly 37 children (36.8) per 1,000 children in the population received a CPS response in permissive reporting states.

Analyses of the rates of children who were determined to be victims of abuse and neglect show slight fluctuations in rates since 2007. The victimization rate is slightly higher for the states with mandated reporting laws.

For 2010, nearly 10 (9.9) children per 1,000 children in the population were determined to be victims of maltreatment in states with mandated reporting laws. For the same year, nine children per 1,000 children in the population were determined to be victims of maltreatment in permissive reporting states.

Figure 2 provides a comparison of the rates of screened-in and screened-out referrals in mandated and permissive reporting states. When an allegation, also called a referral, of child maltreatment is made to CPS agencies, the referral is screened to determine whether it is appropriate for further action. Referrals that do not meet agency criteria are screened out. A referral that is screened in receives a CPS response in the form of an investigation response or alternative response. As shown in Figure 2, states with mandated reporting laws have a lower rate of screened-out referrals than permissive reporting states. Therefore, fewer referrals are screened out. Mandated reporting states have a higher screened-in referral rate, meaning more referrals are receiving a response from CPS agencies.

A report source is the category or role of the person who notified a CPS agency of the allegation of child maltreatment. A professional report source is a person who encountered the alleged child abuse as part of his or her job, such as a day care provider. State laws require most professionals to report suspected abuse, even in permissive states. Nonprofessional report sources are persons who did not have a relationship with the alleged victim based on his or her job, such as a friend or neighbor. The National Child Abuse and Neglect Data System (NCANDS) category of "other" report sources includes relationship categories that are not specified in NCANDS. This may include clergy members, sports coaches, and camp counselors. As shown in Figure 3, regardless of whether a state has mandated or permissive reporting laws, professional report sources submit the largest percentage (more than one-half) of maltreatment reports. Mandated reporting states also have a larger proportion of nonprofessionals and other or unknown sources than permissive reporting states. For example, for 2010, nonprofessional report sources accounted for 31.2 percent in mandated reporting states, while nonprofessional report sources accounted for 25.4 percent in permissive reporting states.

Analyzing caseload data does not provide a clear difference between states with mandated reporting laws and states that do not have these laws. Figure 4 shows that the

number of completed reports per investigation worker has fluctuated during the previous five years. The number of completed reports per investigation worker was determined by dividing the number of completed reports by the number of investigation workers. The number of completed reports in states with mandated reporting laws was at its highest point during 2010 at 67.1 reports per worker. This is similar to the number of completed reports per worker in permissive states, which was 66.1. The number of states that reported the number of investigation workers has not been consistent during the past five years. This is due in part to the fact that some states do not have the ability to break out the number of CPS workers by function and therefore are unable to provide the number of workers who conduct investigations. As CPS agencies realign their workforce to implement multiple response programs (investigations and alternative responses), the methodologies for calculating caseloads may become more complex and state- or county-specific.

Topic II. Legal standard for training of mandated reporters

Which states have a legal standard for the training of mandated reporters, and is that training standardized and funded? What role has HHS played in developing a standardized strategy or curriculum, or otherwise provided guidance to the states on best practices for training mandated reporters? If any states have established such a standard or developed best practices, how has it affected rates of reporting and substantiation?

State policies, laws, and procedures regarding CPS in general, and mandatory reporting specifically, vary by state.[4] As such, each state tailors its training accordingly. There has not been a systematic review of the effectiveness of the training or its impact on reporting by the Department of Health and Human Services (HHS) as of this writing.

As amended by the Child Abuse Prevention and Treatment Act (CAPTA) Reauthorization Act of 2010, Section 106 of CAPTA requires that grant funds be used for the purpose of training individuals who are required to report suspected cases of child abuse and neglect. The Children's Bureau supports the National Resource Center (NRC) on Child Protective Services under CAPTA. NRC provides training to states and localities on topics related to "up-front" CPS, safety decision-making, developing safety plans, and training and technical assistance on topics and systems-change efforts requested by a state.

An example of this work is a curriculum that was developed in response to requests for a child abuse and neglect awareness curriculum that could be used to train managers and

[4] The Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws is available at: http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm. This is an introduction to the State Statute Series section on mandatory reporters.

staff working in emergency shelters during Hurricane Katrina. This curriculum includes a trainer's guide, participant handbook, and safety posters for children and for adults on how to keep children safe from harm in the shelter environment. Although the target audience was the shelter staff, these products were shared widely with federal ACF Central Office and Regional Office staff, and with the general public through posting on the Children's Bureau website. This curriculum was later adapted by ACF's Office of Refugee Resettlement for training of staff in their Unaccompanied Children's shelters.

Additionally, for more than 30 years the Children's Bureau has published a series of User Manuals on child abuse and neglect, beginning with a Basic Manual identifying what is child abuse and neglect, how to report it, what state laws are, and the like. After the initial Basic Manual, there were additional manuals published on a variety of topics, including the role of the educator, the role of the courts, supervision in CPS, first responders, coordinated community response, domestic violence, etc. The last edition of the series was completed in 2010. Over the years, these manuals have been extensively used by agencies, schools of social work, other disciplines, and the interested general public, as evidenced by the utilization rates tallied by the former National Clearinghouse on Child Abuse and Neglect, currently known as the Child Welfare Information Gateway. All the manuals are available at: http://www.childwelfare.gov/pubs/umnew.cfm.

Topic III. State definitions of child abuse that do not include deliberate acts by any individual that lead to death, serious harm or imminent risk of serious harm

Thirty-four states, the District of Columbia, and Puerto Rico (henceforth referred to as "states") have definitions of child abuse that do not include deliberate acts by any individual that lead to death, serious harm, or imminent risk of serious harm. This number was determined by reviewing the states' statutes.[5] There are 36 states in which child abuse and neglect is defined as certain acts or omissions by a parent or caretaker. These states are known as "caretaker-only" statute states. These states are: Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, and Wyoming. In the remaining 16 states, child abuse and neglect is defined as certain acts or omissions by any individual. These are called "any individual" statute states. However, it is important to note that there are variations within these definitions. For example, Vermont, which is considered a "caretaker-only" statute state, investigates sexual abuse allegations perpetrated by any person (*Child Maltreatment 2010,* p. 223).

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[5] Go to: http://www.childwelfare.gov/systemwide/laws_policies/state/

How do state definitions of child abuse differ?

Based on NCANDS State Commentary provided in Appendix D in the annual *Child Maltreatment* report, there are differences in the administrative structure and the level of evidence required to determine a disposition.[6] Of the 52 states, including Puerto Rico and the District of Columbia, 42 have a state-administered structure and 11 have a state-supervised, county-administered structure. These numbers total more than 52 because two states—Nevada and Wisconsin—have a combination of both types of administrative structures.

The majority of states (29) use "preponderance" as the evidence level that needs to be met to determine whether a child was a victim of maltreatment. Ten states use "credible," and two states use the stricter evidence level called "clear and convincing." State-level data is detailed in Table 1: Administration of States and Level of Evidence to Substantiate an Allegation of Child Maltreatment.

What impact do these differences (in definitions of child abuse) have upon how child abuse and neglect is reported, investigated, and prosecuted, as well as a victim's ability to access services and support?

Analysis of NCANDS disposition and victimization by state statute category is reflected in Figure 5. For the states with "caretaker-only" statutes, the child disposition rates defined as the rates of children who received a CPS response were consistently higher than the states with "any individual" statutes. For example, in 2010, the disposition rate was 41.2 per 1,000 children in the population for "caretaker-only" statute states, while the disposition rate was 36.2 per 1,000 children in the population for "any individual" statute states. This means that for every 1,000 children in the population in the "caretaker-only" statute states, approximately 41 children received either an investigation response or alternative response from CPS agencies.

The victimization rates for "caretaker-only" statute states have remained stable for the past three years. The rate for states that investigate any individual had some rate fluctuations, due in part to the implementation of alternative response and safety model programs in several states.

Analyzing data by perpetrator relationship does show some differences between the "caretaker-only" statute states and "any individual" statute states. The "any individual" statute states have a higher proportion of perpetrators with a non-parental relationship of

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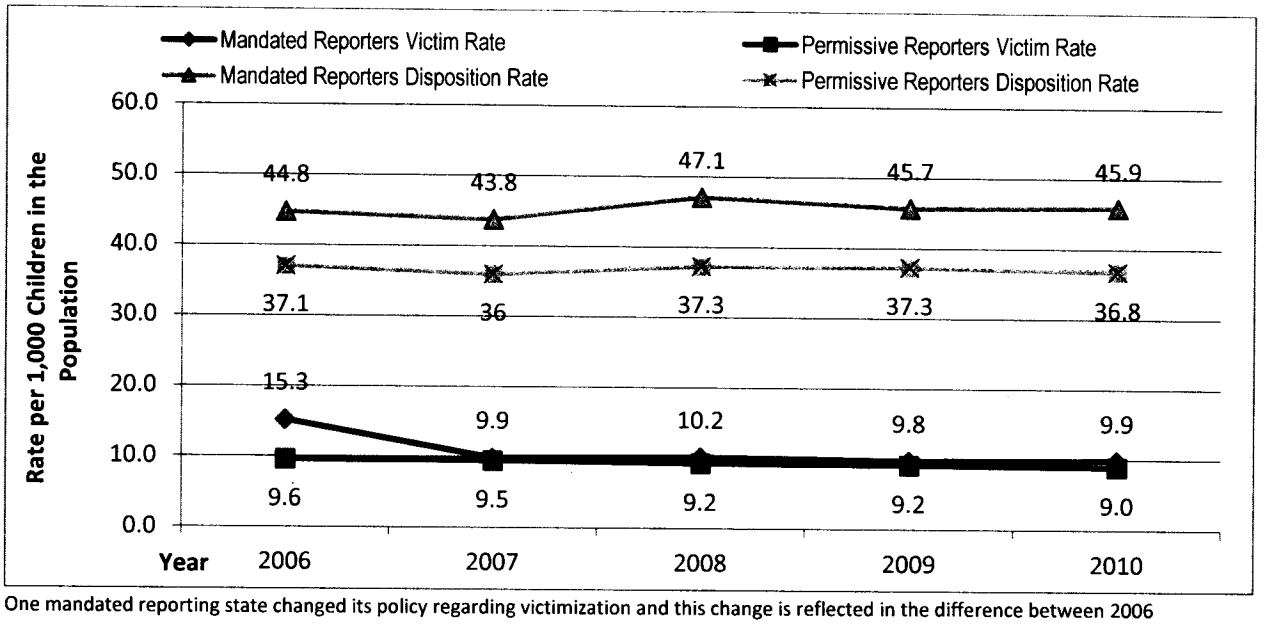
[6] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). Child Maltreatment 2010. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can.

other relative and unmarried partner of parent than the same categories in "caretaker-only" statute states. The exception is for 2007 when Texas had a coding problem with several of the non-parental relationship categories. Texas resolved the issue the following year.

In NCANDS, the term "other relative" is defined as a non-parental family member. For example, for 2010, the percentage of perpetrators with the relationship to the victim of unmarried partner of parent was 6.3 in "any individual" statute states, and 3.9 in "caretaker-only" statute states. In fact, if the non-parental categories are grouped together, the total percentages for the non-parental relationship category is higher in the "any individual" statute states than in the "caretaker-only" statute states for four out of five years (the exception being 2007 with the previously mentioned Texas data).

Appendix A

Figure 1. Disposition and Victimization Rates by Reporting Type, 2006 – 2010



One mandated reporting state changed its policy regarding victimization and this change is reflected in the difference between 2006 and 2007.

Figure 2. Screened-in and Screened-out Referral Rates, 2006-2010

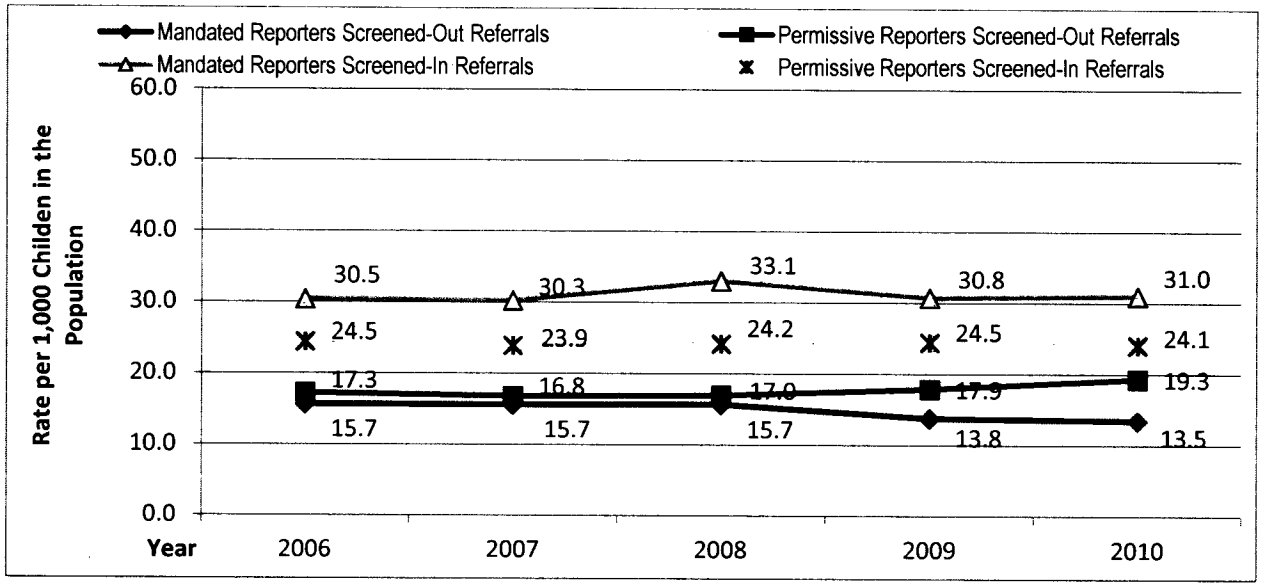


Figure 3. Report Sources, 2006-2010

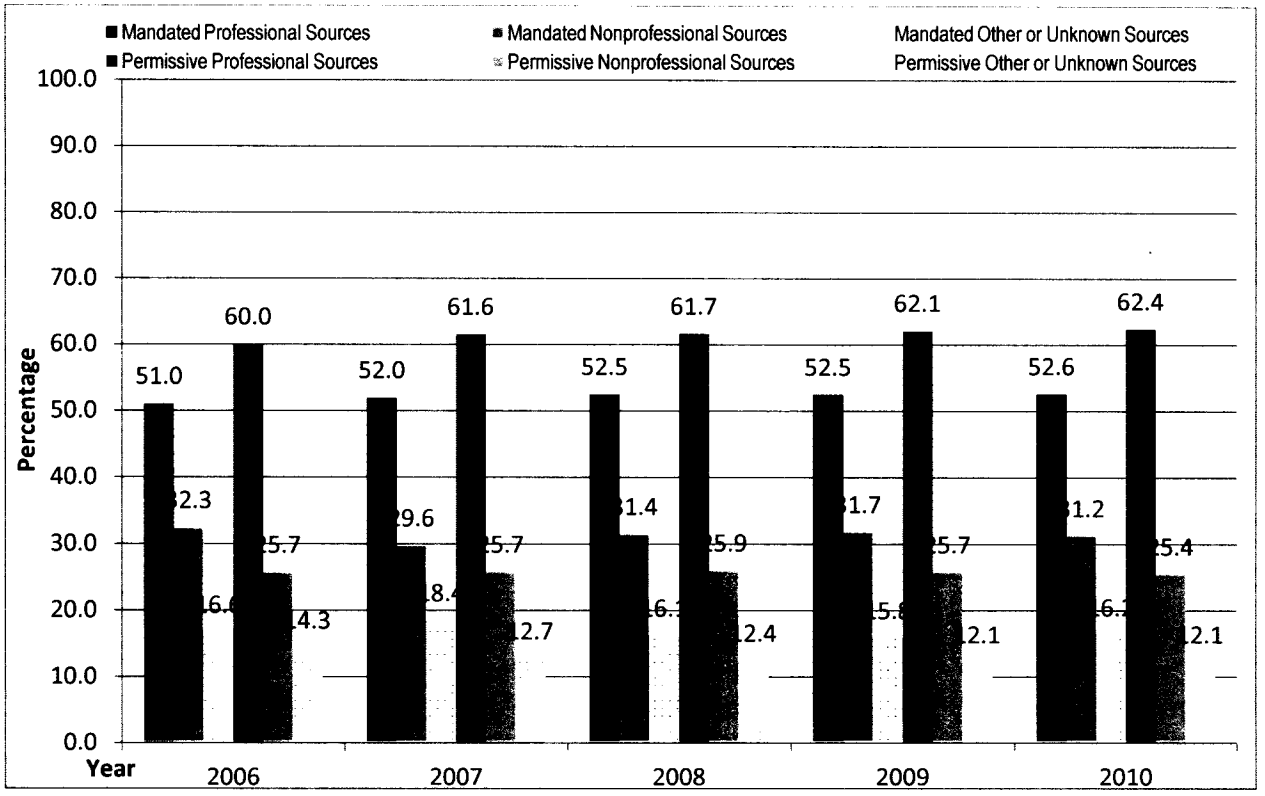


Figure 4. Child Protective Services Caseload, 2006-2010

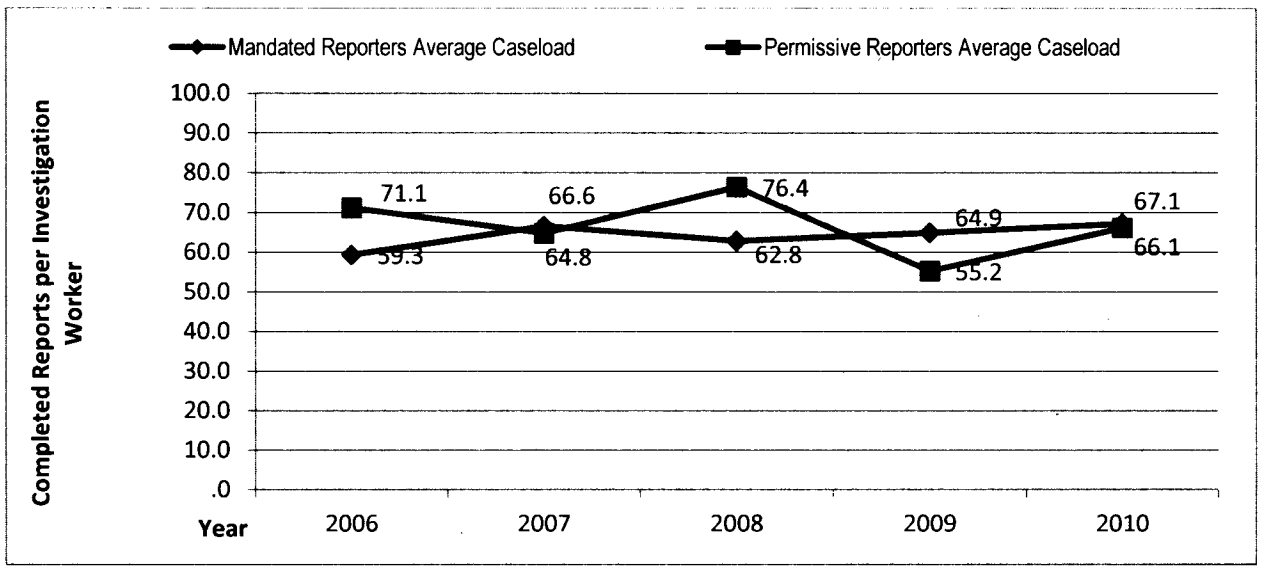
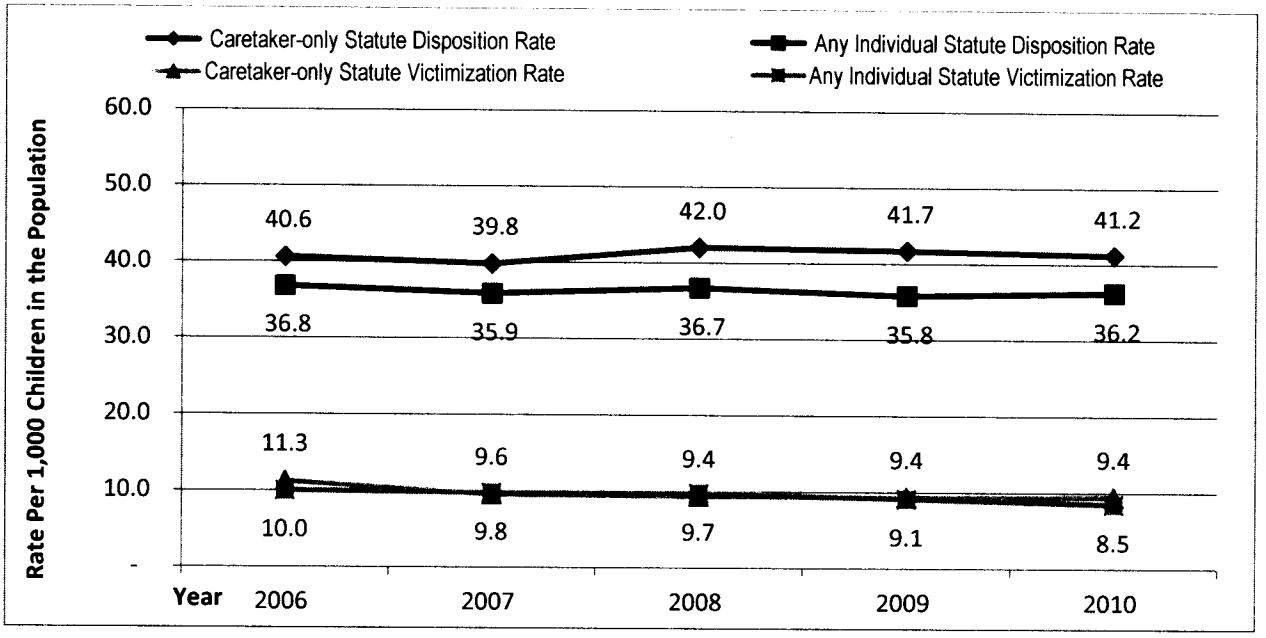


Figure 5. Disposition and Victimization Rates by Statute Type, 2006-2010



Appendix B

Table 1. Administration of States and Level of Evidence to Substantiate an Allegation of Child Maltreatment

State	State Administered	State Supervised, County Administered	Clear and Convincing	Preponderance	Preponderance, Credible (> 50%)	Credible	Reasonable	Probable Cause
Alabama (AL)	X			X				
Alaska (AK)	X						X	
Arizona (AZ)	X							X
Arkansas (AR)	X			X				
California (CA)		X		X				
Colorado (CO)		X		X				
Connecticut (CT)	X						X	
Delaware (DE)	X			X				
District of Columbia (DC)	X					X		
Florida (FL)	X					X		
Georgia (GA)	X			X				
Hawaii (HI)	X						X	
Idaho (ID)	X					X		
Illinois (IL)	X					X		
Indiana (IN)	X					X		
Iowa (IA)	X				X			
Kansas (KS)	X		X					
Kentucky (KY)	X			X				
Louisiana (LA)	X						X	
Maine (ME)	X			X				
Maryland (MD)	X			X				
Massachusetts (MA)	X						X	
Michigan (MI)	X			X				
Minnesota (MN)		X		X				
Mississippi (MS)	X					X		
Missouri (MO)	X			X				
Montana (MT)	X			X				
Nebraska (NE)	X			X				
Nevada (NV)	Both	Both		X				
New Hampshire (NH)	X			X				
New Jersey (NJ)	X			X				
New Mexico (NM)	X					X		

New York (NY)		X				X		
North Carolina (NC)		X		X				
North Dakota (ND)		X		X				
Ohio (OH)		X				X		
Oklahoma (OK)	X					X		
Oregon (OR)	X						X	
Pennsylvania (PA)		X	X					
Rhode Island (RI)	X			X				
South Carolina (SC)	X			X				
South Dakota (SD)	X			X				
Tennessee (TN)	X			X				
Texas (TX)	X			X				
Utah (UT)	X						X	
Vermont (VT)	X						X	
Virginia (VA)		X		X				
Washington (WA)	X			X				
West Virginia (WV)	X			X				
Wisconsin (WI)	Both	Both		X				
Wyoming (WY)	X			X				
States Reporting	**42**	**11**	**2**	**29**	**1**	**10**	**8**	**1**

NOTES

Puerto Rico is not included as we do not know the Commonwealth's level of evidence. The admin structure is State administered, according to the National Association of Public Child Welfare Administrators, although we were not able to confirm this.

Two states--Wisconsin and Nevada have a combination of both types of admin structures. As such, the two states are counted in all 3 admin tables; with the third table all to themselves (See tab labeled both admin).

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 06, 2012

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Waxman:

I am writing today to express the Administration's strong opposition to H.R. 452, the Medicare Decisions Accountability Act of 2011. Repealing the Independent Payment Advisory Board (IPAB) would add billions of dollars to the Federal budget deficit, leave seniors and people with disabilities to shoulder rising health care costs, and eliminate an important tool that will help further strengthen Medicare in the years ahead.

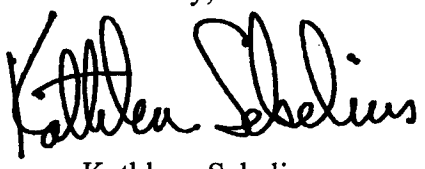
Over the past two years, HHS has focused on working with Congress and our other partners across the country to implement the Affordable Care Act quickly and effectively, including steps to fill gaps in Medicare coverage, improve care for program beneficiaries, and make the program more sustainable for future generations while preserving its guarantees to the beneficiaries it serves. Because of the Affordable Care Act, 3.6 million beneficiaries have already saved $2.1 billion on prescription drug costs while 32.5 million have already taken advantage of free preventive services that will help keep them healthy and out of the hospital. Medicare Advantage enrollment is up, and Medicare premiums are down. HHS has partnered with physicians and hospitals to reduce Medicare's costs by improving patient safety and encouraging health care providers to better coordinate care with one another. We have already engaged 50,000 doctors and hospitals and beneficiaries in all 50 states through the Center for Medicare & Medicaid Innovation. And the Administration's anti-fraud efforts have returned a record $10.7 billion to taxpayers over the last three years.

When it comes to Medicare's fiscal future, we should not take any chances. That is why the Affordable Care Act created IPAB as a backstop to help ensure Medicare remains solvent for future generations. IPAB will be composed of fifteen experts including doctors, consumers, and patient advocates recommended by Congressional leaders, nominated by the President, and confirmed by the Senate. It will recommend policies to Congress to help Medicare provide better care at lower costs. IPAB is explicitly prohibited from recommending cutting benefits, increasing cost-sharing, or rationing care. Starting in 2015, if Medicare cost growth per beneficiary exceeds a growth rate target, IPAB recommendations would take effect only if Congress were to fail to act on them, including by making other changes to strengthen Medicare.

Leading economists including Nobel Prize winners as well as the non-partisan Congressional Budget Office (CBO) have highlighted IPAB as an important contributor to Medicare's long-term sustainability. IPAB will help lower costs and strengthen traditional Medicare – in sharp contrast to the last major Medicare bill passed by the House of Representatives which would shift costs to seniors and end Medicare as we know it.

By repealing IPAB, H.R. 452 would eliminate an important safeguard that will help protect and strengthen Medicare. This bill would raise Medicare costs and the deficit by billions according to an estimate last year by CBO. The Administration strongly opposes this proposed legislation which would erode this important provision of the Affordable Care Act.

Sincerely,



Kathleen Sebelius

Cc:
The Honorable Joe Pitts
The Honorable Frank Pallone

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 06, 2012

The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Camp and Ranking Member Levin:

I am writing today to express the Administration's strong opposition to H.R. 452, the Medicare Decisions Accountability Act of 2011. Repealing the Independent Payment Advisory Board (IPAB) would add billions of dollars to the Federal budget deficit, leave seniors and people with disabilities to shoulder rising health care costs, and eliminate an important tool that will help further strengthen Medicare in the years ahead.

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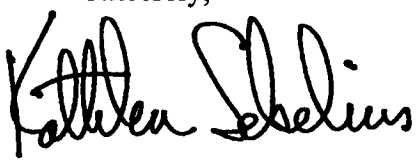


Kathleen Sebelius

Cc:
The Honorable Wally Herger
The Honorable Pete Stark

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

August 10, 2012

The Honorable Kenny Marchant
U.S. House of Representatives
Washington, DC 20515

Dear Representative Marchant:

Thank you for your letter inquiring about the Centers for Medicare and Medicaid Services's review of Texas's request to renew its section 1115 Family Planning Demonstration, entitled "Women's Health Program" (WHP). I appreciate hearing from you on this issue.

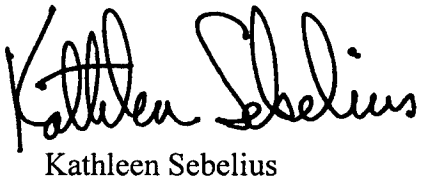
One of the fundamental aspects of the Medicaid program is the statutory provision at section 1902(a)(23)(A) of the Social Security Act, which provides that Medicaid beneficiaries may obtain covered services from any qualified provider willing to undertake the service. Section 1902(a)(23)(B) sets forth additional protections for beneficiary free choice of family planning providers.

To summarize the situation to date, Texas promulgated a state rule that restricts freedom of choice of health care providers for women in the WHP. Consistent with longstanding federal statutory provisions that ensure free choice of family planning providers, the state does not have the authority under the demonstration to impose such a limitation. CMS advised the state in letters dated December 12, 2011, and March 15, 2012, that it would not grant the state that authority. In light of the state's preference to move forward in implementing the state rule, CMS stated that it could not extend or renew the current demonstration except for purposes of phasing out the demonstration. As you may know, CMS does not approve or renew every section 1115 demonstration.

Given the importance of this program for the women of Texas, CMS offered to phase-out the WHP over a period of months, through December 2012, in order to minimize the disruption in care for women enrolled in the program. The phase-out period would permit a transfer of the program, with a more limited set of providers, to a fully state-funded program consistent with Governor Perry's March 8, 2012, letter to President Obama. Then, in a lawsuit filed in U.S. district court in Texas by several WHP providers, the court issued a preliminary injunction that bars the state from enforcing the new rule that restricts freedom of choice of health care providers in WHP. CMS indicated that it would continue to provide funding for WHP while that injunction was in effect, as long as the state verified that it was not applying the rule to any provider. Texas has not provided such confirmation, and it appears to have implemented this improper restriction on beneficiaries' right to free choice of family planning providers. CMS wrote to the state on July 27, 2012, asking again for either confirmation that it is not implementing the rule or, if it cannot provide such confirmation, for a plan for phasing out the federally funded program.

The Department of Health and Human Services understands the important role of the WHP in providing family planning services to the women of Texas. If the state rule were implemented with respect to all WHP providers, providers that furnish a large percentage of all services provided under the WHP would be excluded from the program. We are not overturning state law, but we are assuring that if Texas chooses to continue to use federal Medicaid funding to support the WHP, it must permit the women served by the program to receive their care from the qualified provider of their choice, consistent with federal law. We remain open to working with the state toward the best outcome for Texas women consistent with federal law.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

January 31, 2012

The Honorable Bernard Sanders
United States Senate
Washington, DC 20510

Dear Senator Sanders:

Thank you for your letter regarding the Final Report of the Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas. The Committee was charged with the important task of developing revised underserved and shortage designation methodologies that are fair and equitable, effective in identifying high need areas and populations, and agreeable to the various stakeholder groups and communities.

I am grateful for the hard work of the Committee and recognize the tremendous effort involved in producing the report. As you point out, the Committee analyzed a significant amount of complex data and considered numerous policy options during its deliberations, and the vast majority of Committee members endorsed the final report (by a final vote of 21-2, with 5 members abstaining).

Because the Committee did not reach consensus, defined by Committee members as unanimous consent, a report was transmitted to me instead of an interim final rule. The Department is carefully examining the recommendations set forth in this report as we consider next steps in the rule writing process. As required by the Affordable Care Act, we will publish an interim final rule with revised Health Professional Shortage Areas and Medically Underserved Areas designation methodologies, and the Committee's report will be an invaluable resource as we move forward in this process.

I appreciate hearing your thoughts on adoption of the Committee's recommendations as well as your ongoing commitment to improving the health of our nation's medically underserved. Please contact me with any further thoughts or questions.

Sincerely,

Kathleen Sebelius

Thank you for your continued focus on underserved populations.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

January 6, 2012

The Honorable Claire McCaskill
Chairwoman, Subcommittee on Contracting Oversight
Committee on Homeland Security and Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Madam Chairwoman:

Thank you for writing to the Department of Health and Human Services (HHS) with your request for information regarding how HHS intends to collaborate with the Department of Defense (DOD) to implement a recommendation made by the Institute of Medicine (IOM). As you pointed out in your letter, the IOM recommended that the DOD convene a conference to achieve consensus among a multiagency, multidisciplinary team of clinicians and researchers, including HHS, to establish standardized definitions related to cognitive rehabilitation therapy (CRT) for treatment of traumatic brain injury (TBI).

The panel appointed by the IOM to develop the consensus report, *Cognitive Rehabilitation Therapy for Traumatic Brain Injury: Evaluating the Evidence,* did not include any HHS staff but did include a number of expert researchers who have been funded by the National Institutes of Health (NIH). The committee concluded that current evidence provides limited support for the efficacy of CRT interventions, but that the evidence base is insufficient to develop definitive guidelines for health professionals on whether or how to use CRT. While the DOD has not yet reached out to HHS about planning the recommended conference to strategize about augmenting that evidence base, the NIH and other relevant components of HHS would be pleased to work with the DOD on such a meeting, as resources permit.

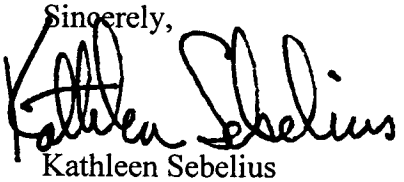
The two agencies already are working together on a range of related activities. The Center for Neuroscience and Regenerative Medicine was established as a collaborative intramural federal program involving the DOD and the NIH to bring together expertise of clinicians and scientists across disciplines to catalyze innovative approaches to assess TBI and promote recovery, with special focus on militarily relevant forms of TBI such as blast, penetrating, and repeat neurotrauma events. Concentrating largely on the patients at the Walter Reed National Military Medical Center, this new Center is also looking at the effect of high anxiety and concurrent development of Post Traumatic Stress Disorder with TBI. In August 2011, the NIH announced a new partnership with DOD to build a central database on traumatic brain injuries. The Federal Interagency Traumatic Brain Injury Research (FITBIR) database, funded at $10 million over four years, is designed to accelerate comparative effectiveness research on treatments and diagnostic tools for brain injuries by collecting new data, linking to current databases, and making it easier to compare results across studies.

On December 8-9, 2011, the NIH, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and the Department of Veterans Affairs jointly sponsored the fourth Annual Trauma Spectrum Conference, "Bridging the Gap Between Research and Clinical Practice of Psychological Health and Traumatic Brain Injury: Prevention, Diagnosis, Treatment and Recovery for the Iraq and Afghanistan Cohort" at the NIH. Presentations included the most up-to-date research findings on TBI, post-traumatic stress and other major depressive disorders, sleep disorders, and integrative telehealth technologies, and an update on the Army STARRS program that focuses on suicide research. A wide array of researchers, clinicians, advocates, military service members, veterans, and families attended.

In addition, research results from other studies funded by the NIH are shared with the DOD on a regular basis, such as findings from the NIH-sponsored Traumatic Brain Injury Clinical Trials Network, which identified nine core outcome measures (both functional and cognitive) to use in clinical trials of patients who had experienced TBI, and the ongoing Citicoline Brain Injury Treatment (COBRIT) clinical trial, which is testing the compound for its potential in enhancing recovery following acute TBI.

I hope this information is useful to you. We would be happy to provide you with further information on any of our ongoing collaborations with the DOD.

Sincerely,



Kathleen Sebelius

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

SEP 30 2011

The Honorable Darrell Issa
Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Issa:

I am following up on your letter requesting a portal for the Committee to the National Directory of New Hires (NDNH). The Administration for Children and Families' Office of Child Support Enforcement maintains the NDNH database, which contains sensitive personal and financial data on most working Americans, as well as those receiving unemployment compensation. As we understand your request, the Committee seeks to investigate the eligibility of individuals for benefits from the Temporary Assistance to Needy Families program and the Federal Employees' Compensation Act. We appreciate the Committee's interest in the NDNH database and would like to meet with your staff so that we can better understand the Committee's needs, provide you with more information about the database, and explore ways in which we can assist you with your investigation.

We look forward to working with you. Our staff will be in touch with your staff.

Sincerely,

Jim R. Esquea

Jim R. Esquea
Assistant Secretary for Legislation
Department of Health and Human Services

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 3, 2011

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

Dear Senator Hatch:

Thank you for your letter related to the Community Living Assistance Services and Supports (CLASS) program. The goal of the CLASS program, passed by Congress last year, is to help Americans prepare for their long-term services and support needs by offering them an affordable, voluntary insurance program providing benefits that would be financed entirely through private premiums. I appreciate and share your interest in ensuring that this program is implemented in a way that guarantees long-term fiscal solvency, as required by law.

The financial sustainability of CLASS and its funding mechanisms have been the subject of considerable public debate since Congress first considered provisions establishing the program in the context of the Affordable Care Act. The Department's Chief Actuary warned in November 2009, four months before the enactment of the Affordable Care Act, that the CLASS program might not be fiscally sustainable. In total, the Department conducted three actuarial analyses of CLASS Act proposals prior to enactment, and one post-enactment. These analyses were posted on the Centers for Medicare & Medicaid Services' website and transmitted to Congress on November 13, 2009, December 10, 2009, January 8, 2010, and April 4, 2010. Each of the analyses raised questions about the financial sustainability of the proposed program. The analyses are available online at:

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Other than the analyses conducted by OACT, HHS's pre-enactment review of long-term care proposals was focused on analyzing premium and participation estimates, including estimates prepared by the Congressional Budget Office and others, in order to explore the potential effects of various drafts of the legislation as they proceeded through the legislative process. These analyses were performed by specialists with Actuarial Research Corporation (ARC) under contract with the Office of the Assistant Secretary for Planning and Evaluation (ASPE). This type of modeling occurred as part of the Department's planning and preparation for potentially new program responsibilities. In addition to such preparation, consistent with the Executive Branch's longstanding practice of providing technical assistance to congressional committees requesting it, HHS staff reviewed various drafts of the proposed legislation and provided

technical assistance to committees of jurisdiction. This technical assistance was informed by the analyses prepared by ARC. The Congressional Budget Office published an analysis of the CLASS Act on November 25, 2009, and the American Academy of Actuaries published an analysis on December 20, 2009.

As you know, I am required to determine whether the program is actuarially sound before proceeding to offer insurance to consumers. Our program development work is guided by that principle. As I said in recent testimony, we will not implement the program unless it is solvent and sustainable, as required by law. There are certain statutory requirements for the CLASS program that cannot be adjusted to enhance program stability. For example, CLASS must be a voluntary program, with no medical underwriting, and benefits must be fully paid for with premiums collected. On the other hand, I have publicly discussed other improvements currently being considered that could enhance program stability over the 75-year period required by the law. These include increasing the employment and earnings requirements, indexing premiums to rise along with benefits, and minimizing the possibility that people will "game" the rules, for example, by serially skipping payments and later re-enrolling while facing minimal or no penalty. These possible plan modifications are consistent with the types of improvements that have been recommended by outside experts such as the American Academy of Actuaries, which we will consider as we develop the program rules.

We are currently responding to several requests related to the CLASS program from committees of jurisdiction and other members of Congress. Moving forward, we will continue to work with these committees and members to respond to their requests and keep them informed. An identical response is being provided to the co-signers of your letter.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 3, 2011

The Honorable John Thune
United States Senate
Washington, DC 20510

Dear Senator Thune:

Thank you for your letter related to the Community Living Assistance Services and Supports (CLASS) program. The goal of the CLASS program, passed by Congress last year, is to help Americans prepare for their long-term services and support needs by offering them an affordable, voluntary insurance program providing benefits that would be financed entirely through private premiums. I appreciate and share your interest in ensuring that this program is implemented in a way that guarantees long-term fiscal solvency, as required by law.

The financial sustainability of CLASS and its funding mechanisms have been the subject of considerable public debate since Congress first considered provisions establishing the program in the context of the Affordable Care Act. The Department's Chief Actuary warned in November 2009, four months before the enactment of the Affordable Care Act, that the CLASS program might not be fiscally sustainable. In total, the Department conducted three actuarial analyses of CLASS Act proposals prior to enactment, and one post-enactment. These analyses were posted on the Centers for Medicare & Medicaid Services' website and transmitted to Congress on November 13, 2009, December 10, 2009, January 8, 2010, and April 4, 2010. Each of the analyses raised questions about the financial sustainability of the proposed program. The analyses are available online at:

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We are currently responding to several requests related to the CLASS program from committees of jurisdiction and other members of Congress. Moving forward, we will continue to work with these committees and members to respond to their requests and keep them informed. An identical response is being provided to the co-signers of your letter.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 3, 2011

The Honorable Mike Enzi
United States Senate
Washington, DC 20510

Dear Senator Enzi:

Thank you for your letter related to the Community Living Assistance Services and Supports (CLASS) program. The goal of the CLASS program, passed by Congress last year, is to help Americans prepare for their long-term services and support needs by offering them an affordable, voluntary insurance program providing benefits that would be financed entirely through private premiums. I appreciate and share your interest in ensuring that this program is implemented in a way that guarantees long-term fiscal solvency, as required by law.

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Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 3, 2011

The Honorable Jeff Sessions
United States Senate
Washington, DC 20510

Dear Senator Sessions:

Thank you for your letter related to the Community Living Assistance Services and Supports (CLASS) program. The goal of the CLASS program, passed by Congress last year, is to help Americans prepare for their long-term services and support needs by offering them an affordable, voluntary insurance program providing benefits that would be financed entirely through private premiums. I appreciate and share your interest in ensuring that this program is implemented in a way that guarantees long-term fiscal solvency, as required by law.

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Sincerely,

Kathleen Sebelius

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 3, 2011

The Honorable Wally Herger
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger:

Thank you for your letter related to the Community Living Assistance Services and Supports (CLASS) program. The goal of the CLASS program, passed by Congress last year, is to help Americans prepare for their long-term services and support needs by offering them an affordable, voluntary insurance program providing benefits that would be financed entirely through private premiums. The need for an affordable mechanism to help Americans plan prudently for their future is well established and guides the Department as we seek to implement the law.

As you know, I am required to determine whether the program is actuarially sound before proceeding to offer insurance to consumers. Our program development work is guided by that principle. As I said in recent testimony, we will not implement the program unless it is solvent and sustainable, as required by the statute. There are certain statutory requirements for the CLASS program that cannot be adjusted to enhance program stability. For example, CLASS must be a voluntary program, with no medical underwriting, and benefits must be fully paid for with premiums collected.

On the other hand, as referenced in your letter, I have publicly discussed other improvements currently being considered that could enhance program stability over the 75-year period required by the law. These include increasing the employment and earnings requirements, indexing premiums to rise along with benefits, and minimizing the possibility that people will "game" the rules e.g. by serially skipping payments and re-enrolling at a later time while facing minimal or no penalty. These possible plan modifications are consistent with the types of improvements that have been recommended by outside experts such as the American Academy of Actuaries. The Department will analyze each option on its merits and its consistency with the law and its intent. For that reason, I appreciate you raising the issue of the Congressional Research Service's analysis of the minimum earnings requirement provisions in the statute, and we will closely evaluate their assessment.

The law directs me to designate a benefit plan by October 2012, after developing three alternative benefit plans, in consultation with actuaries and other experts and presenting these plans to an advisory council composed of consumers, caregivers, and individuals with technical expertise. These three alternative benefit plans will be published as part of a notice of proposed

rulemaking. The regulatory process will follow well-established procedures, as governed by the Administrative Procedure Act. Those procedures include the issuance of a proposed rule that contains a detailed description of the proposed regulation, the legal authority for the proposed regulation, and the proposed regulation itself. Once the proposed rule is published, there will be an opportunity for public comment, usually at least 60 days. We are targeting publication of a notice of proposed rulemaking this fall. In order to maximize public accountability and understanding of any program specifications we propose through the regulatory process, we intend to describe the statutory basis for each of the specifications in the proposed rule.

I look forward to continuing to work with you as we move forward with this process.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 19, 2011

The Honorable Michael B. Enzi
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

Dear Senator Enzi:

Thank you for your March 15, 2011 letter concerning oversight of the Affordable Care Act. At the Department of Health and Human Services (HHS), we are committed to cooperating with Congress in its oversight role. The Department has recently received a large number of congressional oversight inquiries, including letters, requests for testimony and staff briefings, and questions for the record. We will continue to respond to each inquiry thoughtfully and in as timely a manner as possible.

HHS officials have testified at more than thirty House and Senate committee hearings this year, many of them focused on implementation of the Affordable Care Act. I have testified seven times, including twice before the Senate Finance Committee and once before the Senate Health, Education, Labor, and Pensions (HELP) Committee.

Since the enactment of the Affordable Care Act in March 2010, HHS has also provided frequent briefings to House and Senate staff. These have included at least seven bipartisan Senate staff briefings discussing implementation of the Affordable Care Act. Going forward, we would be happy to continue to work with you and your staff to set up briefings as appropriate.

At HHS, we also make a good faith effort to provide timely responses to congressional correspondence, including oversight requests that may require significant departmental resources. Since the passage of the Affordable Care Act, the Office of the Secretary has responded to many oversight letters from the ranking members of the Finance and HELP Committees. HHS's operating divisions have responded to additional letters. We are continuing to respond to letters as they are received.

I believe that congressional oversight can be a constructive, collaborative process, and I look forward to continuing to work with you on these important issues. I will also send a copy of this letter to your co-signer.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 19, 2011

The Honorable Orrin G. Hatch
Ranking Member
Senate Committee on Finance
United States Senate
Washington, DC 20510

Dear Senator Hatch:

Thank you for your March 15, 2011 letter concerning oversight of the Affordable Care Act. At the Department of Health and Human Services (HHS), we are committed to cooperating with Congress in its oversight role. The Department has recently received a large number of congressional oversight inquiries, including letters, requests for testimony and staff briefings, and questions for the record. We will continue to respond to each inquiry thoughtfully and in as timely a manner as possible.

HHS officials have testified at more than thirty House and Senate committee hearings this year, many of them focused on implementation of the Affordable Care Act. I have testified seven times, including twice before the Senate Finance Committee and once before the Senate Health, Education, Labor, and Pensions (HELP) Committee.

Since the enactment of the Affordable Care Act in March 2010, HHS has also provided frequent briefings to House and Senate staff. These have included at least seven bipartisan Senate staff briefings discussing implementation of the Affordable Care Act. Going forward, we would be happy to continue to work with you and your staff to set up briefings as appropriate.

At HHS, we also make a good faith effort to provide timely responses to congressional correspondence, including oversight requests that may require significant departmental resources. Since the passage of the Affordable Care Act, the Office of the Secretary has responded to many oversight letters from the ranking members of the Finance and HELP Committees. HHS's operating divisions have responded to additional letters. We are continuing to respond to letters as they are received.

I believe that congressional oversight can be a constructive, collaborative process, and I look forward to continuing to work with you on these important issues. I will also send a copy of this letter to your co-signer.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 19, 2011

The Honorable Joseph I. Lieberman
Chairman
Homeland Security and Governmental Affairs Committee
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your April 1, 2011, letter requesting information about the engagement of the Department of Health and Human Services (HHS) in the government-wide effort to address violent extremism and terrorist threats within the United States. HHS is an active participant in these important efforts. As described below, we have coordinated our efforts at the federal level primarily through the Interagency Policy Committee related to countering violent extremism. Our primary focus has been to empower refugee communities to resist the influence of terrorist groups and violent ideological movements through the outreach efforts of our Office of Refugee Resettlement (ORR) with community groups, state and local governments, and other partners working to address violent extremism. We hope the following responses to your specific questions are helpful.

1. The National Strategy

a. As you know, the National Security Council (NSC) coordinates an Interagency Policy Committee (IPC) on issues related to countering violent extremism. Sharon Parrott, Counselor to the Secretary for Human Services Policy, and Eskinder Negash, head of the Office of Refugee Resettlement, participate in that IPC and related work groups, including a working group on community engagement. HHS's leadership team on these efforts thus includes a representative from the Office of the Secretary, who can engage with other parts of the Department as needed, as well as the director of the HHS office that directly engages with communities newly integrating into the United States.

b. Through the IPC, we coordinate with a broad range of executive branch departments and agencies. For example, we have provided briefings to the community engagement group on how the Office of Refugee Resettlement works with refugee communities. In addition, we have worked with the Department of Justice to ensure that Anti-Terrorism Advisory Councils in each of the 94 U.S. Attorneys' Offices and the FBI's Joint Terrorism Task Forces understand how state refugee coordinators can help them engage with refugee communities and understand their needs and concerns. HHS officials have also met with representatives of the Somali community in Minneapolis along with our

colleagues at the Department of Education to listen to community concerns about opportunities available to young people in the community and discuss community solutions. The National Counterterrorism Center (NCTC) has met with Department officials on several occasions, and we have provided them with information as requested and received briefings from them through the IPC. In addition, our Office of Security and Strategic Information coordinates information exchange with NCTC.

c. The NSC is the principal venue for coordinating the development and implementation of policies to counter violent extremism. We participate in discussions related to policy development and implementation, including inter-agency working groups.

2. The Department's Understanding of the Threat

HHS is not an intelligence agency, but we have been briefed on issues regarding violent extremism by our colleagues in the intelligence community. We are committed to assisting communities that may be the targets of terrorist recruitment. One area where HHS has a special role to play is with the refugee communities with which we work every day. Refugees come to the United States to start new lives and build new communities. They are a source of strength for the United States, bringing vitality and ingenuity to the nation and the communities in which they live. We work with refugee communities to empower them to reduce the ability of terrorist organizations and other militant groups to recruit or influence members of their communities.

3. The Department's Role

HHS has two main roles with regard to countering violent extremism. First, we work with refugee communities and organizations engaged in resettlement so that they understand the nature of the threat and are working to prevent terrorist organizations or militants from recruiting in their communities. Second, we serve as a resource to other parts of the federal government working to counter violent extremism.

Engaging Refugee Communities and Organizations

In this role, the Department seeks to raise awareness of potential problems and works with community leaders to understand possible solutions. We work to link refugee communities with other parts of the federal government and state and local governments who can help communities protect themselves from recruitment by terrorist organizations and other militant groups.

ORR has engaged in several significant outreach activities with Ethnic Community-Based Organization (ECBO) partners and stakeholders. These engagements have included the participation of the ORR Director in statewide refugee stakeholders' meetings and conferences, as well as one-on-one meetings with ECBO representatives. In each meeting, ORR has taken the

opportunity to address the issue of countering violent extremism and promoting successful integration and acculturation of refugees and asylum seekers in the U.S.

Highlights of these engagements follow:

- ORR convened a meeting with Somali leadership in Arlington, Virginia, to address domestic anti-radicalization efforts within the community, in conjunction with the Ethiopian Community Development Council, a non-profit community-based organization dedicated to helping resettle refugees and promoting cultural, educational and socio-economic development programs in the refugee and immigrant community. The Department of Justice, Department of Education, the Federal Bureau of Investigation's community outreach representative, and the NCTC's Global Engagement Group also participated.

- ORR participated in Ohio's Annual Refugee Stakeholders Conference in October 2010 and met with Ohio-based service providers, refugee groups, and community representatives. The agency explained its vision and role in refugee resettlement, and addressed specific issues of employment, housing, health, social services case management, and refugee youth and education. Agency representatives also met with Somali community leaders and emphasized the strength of the Somali community and benefits of engaging the wider community to promote integration of Somalis into society in the United States.

- The ORR Director traveled to Minneapolis, Minnesota, in August 2010 to address the "Somali Listening Session: Addressing Gangs, Drugs, Domestic Violence and Radicalization Amongst Somali Youth," sponsored by the Minnesota Department of Education's Office of Safe and Drug-Free Schools (OSDFS). A second meeting with community leaders was also held.

- The ORR Director spoke at the Illinois Refugee Stakeholders Conference in Chicago in October 2010 and met with local refugee groups and key community officials to discuss integration issues and community support for refugees, specifically the engagement of youth and anti-radicalization supports through direct engagement and education.

- ORR held its Quarterly Stakeholders Conference Call with representatives from 24 Ethnic Community Based Organizations on November 30, 2010, and raised the need for service providers and ECBOs to be especially aware of conditions leading to radicalization, and the need to promote successful integration and acculturation of refugees and asylum seekers in the U.S.

- The ORR Director traveled to Dearborn, Michigan, in December 2010 to attend and speak at the Michigan Stakeholders Meeting. While there, the Director met with several Arab-

American organizations to discuss the issue of radicalization and promote efforts to counter its spread amongst disaffected members of the community.

- The ORR Director addressed the Georgia Coalition of Refugee Stakeholders as a featured speaker at their annual meeting in February 2011. The Director met with Somali groups and other newly-arrived refugees, as well as state and local officials, to discuss civic engagement and countering violent extremism in the context of successful resettlement and acculturation.

- The Director attended the Florida 2011 Refugee Services Consultation, sponsored by the Florida Department of Children and Families, and met with various refugee groups and key stakeholders to address countering violent extremism and promote successful integration and acculturation practices.

- The Director traveled to Boise, Idaho, in February 2011, to participate in the Idaho Conference on Refugees: "New Decade, New Vision, New Strength." The Director met with the Mayor of Boise, several officials from the Mountain States Group, including the State Refugee Coordinator, and representatives from various refugee groups. Discussions included efforts to counter domestic radicalization and promote healthy acculturation for all arrivals.

- ORR notified Ethnic Community Based Organization grantees of a speech by National Security Council Deputy Director Denis McDonough at the All Dulles Area Muslim Society of Northern Virginia to be webcast the weekend of March 5, 2011. ORR encouraged their participation to listen to the speech discussing the Administration's approach to countering domestic radicalization.

- ORR participated in the Annual Ethnic Grantee Workshop at the Project SOAR Conference in March 2011 sponsored by the International Rescue Committee. ORR visited with Somali refugee representatives and gave a presentation during the conference that discussed domestic radicalization and the need for the refugee resettlement network.

- ORR hosted a meeting with the Somali Bantu Advisory Committee of Columbus, Ohio, on March 8, 2011, and met with Somali Bantu Leadership to discuss family reunification and resettlement challenges.

In addition, ORR has taken the following actions to work in partnership with Ethnic Community Based Organizations:

- ORR invited ECBO grantees and stakeholders to the upcoming ORR 2011 National Consultation, scheduled for August 1 - 4 in Washington, D.C. A representative from the National Security Council has been invited to address the audience during a plenary session.

- ORR holds regular conference calls with ECBOs, State Refugee Coordinators, and State Refugee Health Coordinators to encourage all partners to work with law enforcement officials—from community-based peace officers to the FBI—to raise community awareness of conditions contributing to radicalization and ways to counter them.

Serving as a Resource to Other Government Agencies

Second, HHS serves as a resource to other federal agencies working to counter violent extremism. For example, when the Departments of Justice or Homeland Security meet with communities to hear their concerns and develop strategies for addressing them, community members may raise issues and concerns on which HHS has expertise, such as domestic violence or bullying in schools. HHS is then prepared to help respond to these issues by providing information and community contacts that can help the community and our federal partners find solutions.

Both of these roles are accomplished within our current authorities. The Office of Refugee Resettlement is authorized to work with refugee communities on issues of social and economic integration. Helping these communities reduce the ability of terrorist organizations and other militant groups to recruit or influence community members is an important part of that work.

4. The Department's Resources

The Department accomplishes these roles within our current resources, and does not have dedicated funding or staff for these purposes. As described above, this work is an important part of the mission of ORR and the Department.

At HHS, we take seriously our role in the government-wide effort to address violent extremism and terrorist threats within the United States. We are grateful for the Committee's leadership in this area, and we look forward to continuing to work with you on these important efforts. A similar response has been sent to Senator Collins.

Very truly yours,

Kathleen Sebelius

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
Administration on Aging

Washington D.C. 20201

March 30, 2011

The Honorable Frank Pallone, Jr.
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Pallone:

Thank you for your March 23, 2011 letter seeking clarity in my statements before the House Committee on Energy and Commerce, Subcommittee on Health hearing on March 17, 2011. I appreciate the opportunity to provide a more comprehensive response to questions regarding the estimated savings attributed to the Community Living Assistance Services and Supports (CLASS) program by the Congressional Budget Office (CBO).

As I stated in my testimony, the goals of the CLASS program are to provide an opportunity for individuals to take responsibility and prepare financially for their own long-term needs, support consumer choices related to their own care and living arrangements, and facilitate independence and community living. The law clearly states that the program must be able to pay for benefits with the premiums it takes in and that no taxpayer dollars may be used to pay for CLASS benefits.

We continue to explore several areas within our statutory flexibility to strengthen the CLASS program, and President Obama and Secretary Sebelius have pledged to use the discretion already provided in the law to make necessary changes to ensure that CLASS meets its programmatic goals and is financially solvent and stable.

As I testified at the Subcommittee hearing, the CBO estimates the Affordable Care Act will reduce the deficit by $210 billion in the first decade and $1 trillion in the next decade. In developing these estimates, CBO is following the same budgeting methods put into law in 1990 and used for more than two decades. These budgeting practices have been used by the Medicare program for many years. Since 1981, the CBO and the Medicare Trustees have prepared estimates for specific statutory changes that would achieve savings in Medicare and extend the solvency of the Medicare Part A Trust Fund while contributing to deficit or surplus calculations. For example, this process was used to estimate savings during the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005.

As Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, recently testified in the same hearing before the Energy and Commerce Committee Subcommittee on Health, this approach is a method that has been in use for many years and is not a budgeting gimmick and should not be considered double counting.

To better understand these budgetary calculations, it is important to note that the premium revenues of the CLASS program, like other trust fund revenues, are part of the larger unified federal budget. Under current budget practices, CLASS revenues and costs are taken account of on an annual basis. Therefore, CLASS premiums are treated as revenue and in the absence of CLASS expenditures contribute to deficit reduction. When CLASS benefits become payable they will be treated as reductions against accumulated premium revenue. This is similar to the treatment of revenues and expenditures from the Medicare Trust Fund.

CLASS premiums will be deposited into a trust fund called the CLASS Independence Fund, which will be managed by the Secretary of the Treasury and Board of Trustees. A primary function of the Board of Trustees is to review program operation and ensure that CLASS is actuarially sound and fiscally solvent over the 20 and 75 year periods stipulated in the law. This is particularly important because no taxpayer funds may be used to pay for CLASS program benefits.

Thank you again for the opportunity to testify before the Subcommittee and for your important questions. We remain strongly committed to transparency as we work to strengthen the CLASS program, and look forward to working with you and your colleagues to ensure responsible and successful implementation. A similar response has also been provided to Representative Waxman.

Sincerely,

Kathy Greenlee

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 30, 2011

The Honorable Frank Pallone, Jr.
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Pallone:

Thank you for your March 23, 2011 letter regarding my statements before the Committee on Energy and Commerce on March 3, 2011. I remain committed to working with you and your colleagues to ensure successful implementation of the Affordable Care Act, and appreciate the opportunity to respond directly to questions regarding efficiencies in the Medicare program.

It is important to reiterate the facts: the new law will not cut guaranteed benefits for seniors or alter the current protections for Medicare beneficiaries. In fact, the Affordable Care Act will add benefits such as free prevention services, an annual wellness visit, and a phase-out of the Medicare donut hole in the prescription drug benefit. Moreover, by reducing waste, fraud, and abuse and cracking down on overpayments, the law will lower beneficiary premiums, reduce beneficiary cost sharing and, as I stated in my testimony, slow the projected growth rate of Medicare over 10 years, extending the life of the Medicare Hospital Insurance Trust Fund by 12 years.

As I have testified, the Congressional Budget Office (CBO) estimates that the Affordable Care Act will reduce the deficit by $210 billion in the first decade and $1 trillion in the next decade. Additionally, the Medicare Trustees estimated that the Medicare trust fund will remain solvent for an additional 12 years because of changes called for in the Affordable Care Act.

In developing these estimates, CBO and the Trustees are following the budgeting methods put into law in 1990 and used for more than two decades. Similarly, since 1981, Republican and Democratic Congresses alike have enacted at least ten laws that the CBO and the Medicare Trustees estimated would achieve savings in Medicare, extending the solvency of the Medicare Part A Trust Fund and reducing the deficit. For example, this process was used to estimate savings during the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005.

As Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, recently testified before the Energy and Commerce Committee Subcommittee on Health, this budgeting method has been in use for many years and is not a budgeting gimmick. CBO is not double counting.

To better understand these budget calculations, it is important to note that the Medicare savings, like other trust fund savings, are part of a larger deficit calculation. Under these longstanding budget practices, Medicare spending is part of the unified federal budget. Therefore, program changes that reduce the growth in spending contribute to reducing the budget deficit. When these changes specifically affect Medicare Part A spending, they also favorably affect solvency projections for the Hospital Insurance Trust Fund.

Paul Van de Water, a Senior Fellow at the Center on Budget and Policy Priorities, also recently testified that there is no double counting in recognizing that Medicare savings improve the status of both the Federal budget and the Medicare Trust Funds. He gave an example, "In the same way, when a baseball player hits a homer, it both adds one run to his team's score and also improves his batting average. Neither situation involves double-counting."

Thank you again for your letter and for seeking clarity in my responses to these important questions. I look forward to continuing to work with you and your colleagues to responsibly implement the Affordable Care Act and deliver its benefits to the American people. A similar response has also been provided to Representative Waxman.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 30, 2011

The Honorable Henry A. Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Waxman:

Thank you for your March 23, 2011 letter regarding my statements before the Committee on Energy and Commerce on March 3, 2011. I remain committed to working with you and your colleagues to ensure successful implementation of the Affordable Care Act, and appreciate the opportunity to respond directly to questions regarding efficiencies in the Medicare program.

It is important to reiterate the facts: the new law will not cut guaranteed benefits for seniors or alter the current protections for Medicare beneficiaries. In fact, the Affordable Care Act will add benefits such as free prevention services, an annual wellness visit, and a phase-out of the Medicare donut hole in the prescription drug benefit. Moreover, by reducing waste, fraud, and abuse and cracking down on overpayments, the law will lower beneficiary premiums, reduce beneficiary cost sharing and, as I stated in my testimony, slow the projected growth rate of Medicare over 10 years, extending the life of the Medicare Hospital Insurance Trust Fund by 12 years.

As I have testified, the Congressional Budget Office (CBO) estimates that the Affordable Care Act will reduce the deficit by $210 billion in the first decade and $1 trillion in the next decade. Additionally, the Medicare Trustees estimated that the Medicare trust fund will remain solvent for an additional 12 years because of changes called for in the Affordable Care Act.

In developing these estimates, CBO and the Trustees are following the budgeting methods put into law in 1990 and used for more than two decades. Similarly, since 1981, Republican and Democratic Congresses alike have enacted at least ten laws that the CBO and the Medicare Trustees estimated would achieve savings in Medicare, extending the solvency of the Medicare Part A Trust Fund and reducing the deficit. For example, this process was used to estimate savings during the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005.

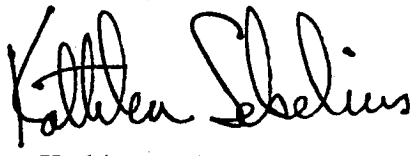
As Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, recently testified before the Energy and Commerce Committee Subcommittee on Health, this budgeting method has been in use for many years and is not a budgeting gimmick. CBO is not double counting.

To better understand these budget calculations, it is important to note that the Medicare savings, like other trust fund savings, are part of a larger deficit calculation. Under these longstanding budget practices, Medicare spending is part of the unified federal budget. Therefore, program changes that reduce the growth in spending contribute to reducing the budget deficit. When these changes specifically affect Medicare Part A spending, they also favorably affect solvency projections for the Hospital Insurance Trust Fund.

Paul Van de Water, a Senior Fellow at the Center on Budget and Policy Priorities, also recently testified that there is no double counting in recognizing that Medicare savings improve the status of both the Federal budget and the Medicare Trust Funds. He gave an example, "In the same way, when a baseball player hits a homer, it both adds one run to his team's score and also improves his batting average. Neither situation involves double-counting."

Thank you again for your letter and for seeking clarity in my responses to these important questions. I look forward to continuing to work with you and your colleagues to responsibly implement the Affordable Care Act and deliver its benefits to the American people. A similar response has also been provided to Representative Pallone.

Sincerely,



Kathleen Sebelius

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

March 25, 2011

The Honorable Danny Rehberg
Chairman
Subcommittee on Labor, Health and Human Services
Education and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Rehberg:

Secretary Sebelius has asked me to respond on her behalf to your March 18, 2011 letter regarding the Community Living Assistance Services and Supports (CLASS) program.

As you know, CLASS is a national voluntary insurance program to assist working Americans in investing in their future long-term care needs. Over 10 million people need long-term services and supports and by 2020 that number is expected to be 15 million. It has been estimated that $230 billion was spent on these services in 2008 to help these individuals with daily living. In addition to these paid services, many more rely primarily on unpaid care provided by family and friends. The CLASS program represents a significant new opportunity for working Americans to financially prepare to remain as independent as possible under a variety of future health circumstances.

The Affordable Care Act requires HHS to develop a benefit plan that achieves the goals of the CLASS program, while ensuring fiscal solvency for a 75 year period, and without using taxpayer dollars to pay for benefits. We have not proposed legislative changes to the program, as the law provides sufficient flexibility in its current form. As the Secretary has said publicly, program characteristics being examined in the context of their impact on fiscal solvency include:

- Employment and earnings requirements;
- Appropriate incentives to prevent gaming of the premium payments;
- Indexing premiums for inflation so they rise along with benefits;
- Tailoring benefits to meet individual needs and preferences;
- Public education regarding long-term care needs and how this program can help families plan for the future;
- Partnerships with employers to disseminate outreach information and enroll their employees; and
- Robust waste, fraud, and abuse regulations and procedures.

We are committed to full transparency as we develop the details of this program. Consistent with the law, we will present three solvent benefit plans to the CLASS Independence Advisory Council. The public will have the opportunity to comment on the plans and the implementation of regulations through notice-and-comment rulemaking, which will occur before the Secretary designates a plan by October 1, 2012.

Many analyses of the CLASS program have been conducted, both prior to and since enactment of the legislation. Most prominently, the American Academy of Actuaries conducted an independent, widely circulated, publicly available analysis of an earlier version of the CLASS Act in July 2009. Analyses were also published by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) Actuary, which informed Congress and the public that the program, as envisioned at that time, was not sustainable. These reports are available at:

- http://www.actuary.org/pdf/health/class_july09.pdf
- http://www.cms.gov/ActuarialStudies/Downloads/HR3962_2009-11-13.pdf
- http://www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2009-12-10.pdf
- http://www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf
- http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf

HHS did not conduct studies on the long-term solvency of CLASS before it was enacted. However, prior to enactment, HHS used existing models to analyze potential premiums and participation rates. When it appeared likely that the legislation would be enacted, HHS began to refine its actuarial modeling capacity so it would be prepared to run models once the legislation passed. My understanding is that in the discussions with House and Senate staffers on March 4, 2011 that are referenced in your letter, Richard Frank, Deputy Assistant Secretary in the HHS Office of Planning and Evaluation, did not indicate that HHS conducted actuarial analysis of the sustainability of the CLASS program before it was enacted. I understand he advised that HHS had reviewed all of the publicly available actuarial analyses related to solvency conducted both before and subsequent to enactment of the Affordable Care Act, including the publicly available reports from the American Academy of Actuaries, CBO, and the CMS Actuary.

During December 2009 and January 2010, the Department responded to requests by staff of the House Committee on Ways and Means, the House Committee on Energy and Commerce, and the Senate Health, Education, Labor and Pensions Committee for technical assistance on proposed reforms to improve the CLASS program.

We hope that the foregoing information and referenced documents are helpful. The Department is committed to a financially strong CLASS program and we look forward to working with Congress to ensure successful implementation.

Sincerely,

Jim R. Esquea

Jim R. Esquea
Assistant Secretary for Legislation

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 24, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515-6115

Dear Mr. Chairman:

Thank you for your letter regarding the inclusion of voluntary advance care planning in the final Medicare physician fee schedule regulation. I would like to take this opportunity to correct some misimpressions and to state the Administration's policy on voluntary advance care planning. I would also like to affirm that the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) support the use of notice-and-comment rulemaking as an important aspect of a transparent regulatory process.

The Administration firmly believes that decisions about end-of-life care should be made by patients, their families, and their doctors – without government interference – and that their choices should reflect the intentions of patients. Nothing in Medicare law or payment policy precludes this, and prior laws and regulations supported by previous Administrations and both Democratic and Republican members of Congress allow and encourage such conversations on a voluntary basis.

The proposed 2011 Medicare physician payment rule, published by CMS in July 2010, included the elements for the visit specifically required by the Affordable Care Act as well as several additional items. The Affordable Care Act specifically permits other elements to be added as appropriate by the Secretary.

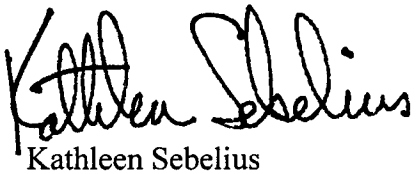
Several interested stakeholders commented that the Welcome to Medicare visit includes advance care planning as a voluntary element of the visit, but the proposed rule did not include this within the new Annual Wellness Visit. In response to these public comments, CMS added voluntary advance care planning – in the same manner as defined by the Bush Administration in a 2008 regulation for the Welcome to Medicare visit – as a specified element of the Annual Wellness Visit in the final rule.

After publication of the final rule, CMS decided to amend the rule to include only the elements that we had proposed for the visit, which do not include voluntary advance care planning. We made this decision in light of the fact that a broad range of stakeholders had not had an

opportunity, prior to CMS issuing the final rule, to offer their views on this subject. On January 10, 2011, CMS issued an amendment to the final rule to strike the language regarding voluntary advance care planning in the Annual Wellness Visit.

My staff would be happy to discuss this issue with you and the Committee staff. I will also provide this response to the cosigners of your letter.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 24, 2011

The Honorable Cliff Stearns
Chairman
Subcommittee on Oversight and Investigations
U.S. House of Representatives
Washington, DC 20515-6115

Dear Mr. Chairman:

Thank you for your letter regarding the inclusion of voluntary advance care planning in the final Medicare physician fee schedule regulation. I would like to take this opportunity to correct some misimpressions and to state the Administration's policy on voluntary advance care planning. I would also like to affirm that the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) support the use of notice-and-comment rulemaking as an important aspect of a transparent regulatory process.

The Administration firmly believes that decisions about end-of-life care should be made by patients, their families, and their doctors – without government interference – and that their choices should reflect the intentions of patients. Nothing in Medicare law or payment policy precludes this, and prior laws and regulations supported by previous Administrations and both Democratic and Republican members of Congress allow and encourage such conversations on a voluntary basis.

The proposed 2011 Medicare physician payment rule, published by CMS in July 2010, included the elements for the visit specifically required by the Affordable Care Act as well as several additional items. The Affordable Care Act specifically permits other elements to be added as appropriate by the Secretary.

Several interested stakeholders commented that the Welcome to Medicare visit includes advance care planning as a voluntary element of the visit, but the proposed rule did not include this within the new Annual Wellness Visit. In response to these public comments, CMS added voluntary advance care planning – in the same manner as defined by the Bush Administration in a 2008 regulation for the Welcome to Medicare visit – as a specified element of the Annual Wellness Visit in the final rule.

After publication of the final rule, CMS decided to amend the rule to include only the elements that we had proposed for the visit, which do not include voluntary advance care planning. We made this decision in light of the fact that a broad range of stakeholders had not had an

opportunity, prior to CMS issuing the final rule, to offer their views on this subject. On January 10, 2011, CMS issued an amendment to the final rule to strike the language regarding voluntary advance care planning in the Annual Wellness Visit.

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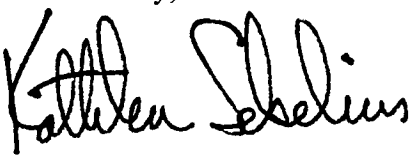

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 24, 2011

The Honorable Joseph Pitts
Chairman
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515-6115

Dear Mr. Chairman:

Thank you for your letter regarding the inclusion of voluntary advance care planning in the final Medicare physician fee schedule regulation. I would like to take this opportunity to correct some misimpressions and to state the Administration's policy on voluntary advance care planning. I would also like to affirm that the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) support the use of notice-and-comment rulemaking as an important aspect of a transparent regulatory process.

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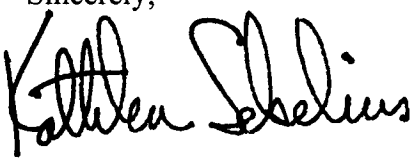

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 24, 2011

The Honorable Phil Gingrey
Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515-6115

Dear Representative Gingrey:

Thank you for your letter regarding the inclusion of voluntary advance care planning in the final Medicare physician fee schedule regulation. I would like to take this opportunity to correct some misimpressions and to state the Administration's policy on voluntary advance care planning. I would also like to affirm that the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) support the use of notice-and-comment rulemaking as an important aspect of a transparent regulatory process.

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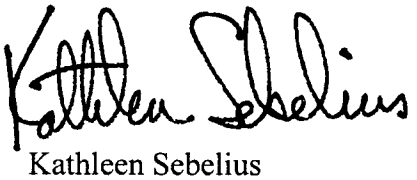


Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 8, 2011

The Honorable Geoff Davis
Chairman, Subcommittee on Human Resources
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

It was a pleasure testifying before the Committee on Ways and Means. Thank you for your recent letter regarding reauthorization of the Temporary Assistance for Needy Families (TANF) program, following up on our discussion at the hearing. I am pleased to see from your questions that we are both interested in considering policy changes in TANF.

The Administration would like to explore with Congress a variety of strategies to strengthen the TANF program's ability to improve outcomes for families and children. This includes considering the development of performance measures that focus on employment-centered outcomes as a mechanism for driving program improvement. While the economy is improving, unemployment remains high and makes the task of helping parents connect or reconnect to jobs more important than ever.

As you know, states are the engines of implementation in the TANF program, and they work directly with employers, training providers, communities, and families. We have held discussions with our state partners about the best steps to take on TANF, and we have repeatedly heard that states want federal rules to focus more on achieving positive outcomes for families and less on burdensome documentation requirements and prescriptive rules. For example, a number of states have expressed concern that current provisions limit their ability to engage some parents in education and training in situations where it would provide the surest path to gaining and retaining employment.

In the course of our extensive work with states on the implementation of the TANF Emergency Contingency Fund (TANF ECF), we met with many states that were actively engaging employers in subsidized employment programs. States enthusiastically embraced the opportunity to partner with employers and to create subsidized jobs programs for parents and disadvantaged youth who were out of work. We believe that lessons learned from the TANF ECF should be considered when reauthorizing TANF.

We also talked with participating employers who reported that their businesses were strengthened by the subsidized employment program and that the employees were a real asset to their businesses. Research commissioned by the Department of Health and Human Services (HHS) provides valuable insights about who is likely to hire TANF recipients, how employers fill their positions, and the types of skills employers need. We have found that employers are often skeptical that welfare recipients possess the necessary attitudes toward work and soft skills. Employers also are concerned that barriers, such as lack of transportation and child care, limit recipients' productivity in the workplace. Based upon our discussions and the research findings, I believe we can improve outcomes for families and children and continue to forge new partnerships with businesses if we develop new policies, including the expansion of subsidized employment efforts. We would be happy to discuss with your staff further mechanisms for seeking stakeholder input, including from the business community.

In your letter, you also asked about work disincentives. As you know, the need to reduce disincentives to work has long been recognized, and much progress has been made. Since passage of the Earned Income Tax Credit (EITC) in 1975, we have made great strides in improving supports and incentives for work. This has included significant expansions in tax-based work supports, such as the EITC, the child tax credit, and the dependent care tax credit. These tax credits are only available to working families and provide help to families at higher income levels than more traditional benefit programs, such as TANF.

Traditional benefit programs also have undergone significant change to improve work incentives and supports. The shift from the Aid to Families with Dependent Children program to TANF created a stronger focus on work. Over the last two decades, the share of Supplemental Nutrition Assistance Program (SNAP) households with earnings has substantially risen, and changes have been made at the federal and state level to make the program more accessible to eligible working families. The Child Care and Development Fund provides support to low-income working parents so that they can work and have affordable, quality care for their children. The Medicaid program used to provide health coverage only to families receiving welfare, but since the 1980s Medicaid and later the Children's Health Insurance Program (CHIP) have increasingly supported working families by providing affordable coverage to millions of children in working families with modest incomes. In 2009, most children participating in Medicaid or CHIP lived in families with earnings.

This Administration continues to build upon these critical work supports. For example, the Affordable Care Act extends affordable health coverage and the increased financial security that comes with insurance to working individuals and families. In 2014, families will no longer have to worry that getting a job or a modest pay raise will mean that they lose health insurance through Medicaid without having access to affordable coverage for themselves or their children. The continuum of help, from Medicaid to tax credits and cost sharing reductions for private coverage in state-run Exchanges, will provide important additional support to working families.

While there are a number of programs designed to help low-income families in their work efforts, research has found that most low-income families do not receive all of the supports for which they are potentially eligible. This may be the case for several reasons. In some cases, families do not need a particular benefit even though they may meet the financial eligibility criteria. In other cases, families may not be aware of the supports that are available. In these cases, outreach is an important tool to help connect families to assistance that can help them retain employment and meet their children's health and other needs. Finally, some families do not receive assistance when funding constraints mean that not all eligible families can be served. For example, a number of states have waiting lists for child care assistance.

States are at the hub of most, though not all, work supports. Some states have taken significant steps to coordinate programs and meet clients' needs. A number of states have worked with the federal government to simplify rules in programs such as Medicaid and SNAP to reduce the paperwork burdens eligible families can face when they apply for benefits. States have made significant progress in the expanded use of online applications, call centers, phone interviews, document imaging, and other advances in technology to improve administrative efficiency and reduce the amount of time working families have to take off from work to apply for or renew eligibility for SNAP, Medicaid, CHIP, and other benefits.

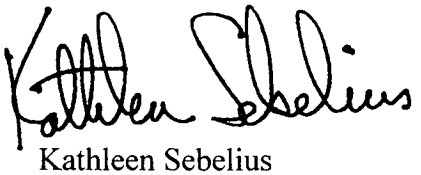
These kinds of initiatives require state leaders to work across program boundaries to find innovative ways to help families and promote efficient use of resources. At the federal level, the Administration is working hard to foster that kind of collaboration and innovation. For example:

- HHS recently published a final regulation on the Advance Planning Document Process. This regulation governs state systems development for Medicaid, child welfare, and child support, as well as the allocation of systems development costs for TANF. The goal of the regulation is to encourage states to bring innovative information technology to fruition by simplifying and streamlining federal requirements for lower-risk projects, while increasing independent oversight of higher-risk ones. These new rules will enable states to move more quickly and boldly from developing new approaches to actually putting them into use, while maintaining responsible stewardship of federal funds.

- HHS and the Department of Labor (DOL) are working to improve strategy-focused planning and promote improved alignment and integration of workforce, TANF, and other relevant programs. For example, HHS and DOL partnered in 2010 to encourage local coordination between TANF agencies and local workforce boards in the implementation of subsidized employment efforts using resources available through the TANF Emergency Contingency Fund. HHS and DOL sent a joint letter to TANF agencies and workforce boards describing the potential for coordination in subsidized employment efforts, and followed up with a set of trainings, conference presentations, and individualized technical assistance to support local initiatives for adult and youth employment.

I am ready to work with you in a bipartisan effort to strengthen the TANF program to provide recipients with the greatest opportunity for attaining employment. Please feel free to contact me or my staff to discuss ways in which we can begin our work together.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 13, 2011

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

Dear Senator Hatch:

Thank you for your letter concerning the regulatory process involved in the implementation of the Affordable Care Act and other regulations by the Department of Health and Human Services (HHS or Department). I share your commitment to giving the public ample opportunity to comment on proposed rules and welcome Congressional review of the rule-making process.

I would like to assure you that the Department takes seriously its compliance with the Congressional Review Act and with the Executive Orders on Federalism (EO 13132) and Regulatory Planning and Review (EO 12866). Moreover, in Executive Order 13563, President Obama emphasized that the regulatory process "must allow for public participation and an open exchange of ideas." I fully support this goal. In order to promote an open exchange, the order instructs agencies to make it a priority to provide the public with a meaningful opportunity to participate in the regulatory process, including the use of the Internet to receive public comments. Agencies are also encouraged, to the extent feasible and consistent with the law, to provide access to the rulemaking docket and relevant scientific and technical findings in an open format that can be easily searched and downloaded.

Consistent with the Executive Order 13563, the Department's goal is to provide at least 60 days for public comment, to the extent feasible and permitted by law. By utilizing modern tools and technology, the Department provides increased opportunities for the public to contribute ideas that will lead to better rules.

It is HHS policy to include substantial legal and policy justifications for each regulatory proposal, including references to the Department's specific statutory authority and the necessary supporting data analysis and discussion. HHS rules also inform stakeholders and the general public about the Department's proposals and the reasoning underlying them so that commenters fully understand and respond effectively to proposed rules. Furthermore, the Department's final rules appropriately reflect not only issues that were raised by the proposed rules, but also relevant issues raised in public comments. Our policy is to respond fully to comments that raise substantive concerns about issues presented by regulatory proposals with significant economic impact.

The Department's rulemaking responsibilities are carried out with broad input from within the Department and throughout the Executive Branch. Drafts of all proposed and final regulations are reviewed by relevant components of the Department, including legal, policy, and budgetary staff. Significant regulations are also reviewed in draft form by the Office of Management and Budget (OMB), which circulates drafts to other affected agencies. The Comptroller General also assesses compliance with the Congressional Review Act, and the Small Business Administration's Office of Advocacy reviews compliance with the Regulatory Flexibility Act.

Regarding changes between proposed and final rules, I take seriously the role of affected stakeholders and the general public in commenting on proposed rules and on interim final rules with comment periods. In many cases, the Department hosts open forums and engages affected stakeholders in extensive dialogue. I am proud that this Department has been a pioneer in electronic rulemaking by ensuring that comments on rules are posted online in a timely manner so that commenters can view others' opinions. When commenters identify significant problems with particular provisions, or suggest alternatives that may be more effective or less costly, HHS analyzes their input with particular care.

When rules are displayed on the Office of the Federal Register's website, they are immediately available to the public (http://www.ofr.gov/inspection.aspx). Sometimes, in order to meet a tight Congressional deadline (especially with regard to newly enacted statutes) or to serve a public interest in expediency, the Department may make rules available for comment upon initial display on the website of the Office of the Federal Register.

You ask for information on forthcoming rules with an economic impact of $100 million or more. Twice a year, the Federal Register includes the Semi-Annual Unified Regulatory Agenda, which announces and describes all rules that the Department plans to publish, and contains information on whether or not they are likely to have an impact of $100 million. This Agenda identifies target publication dates for rules the Department anticipates publishing during a 12-month period (see http://www.reginfo.gov/public/do/eAgendaMain). Also, CMS generally announces on the first day of each quarter the regulations it intends to publish during the quarter (http://www.cms.gov/QuarterlyProviderUpdates/). This CMS website (referred to as the Quarterly Provider Update) is a listserv; anyone can subscribe to it to automatically receive notice of CMS regulations on the day they publish. In addition, OMB provides information about the status of regulatory actions under review (http://www.reginfo.gov/public/do/eoPackageMain) consistent with Executive Order 12866.

You also request that your office be notified when major rules are transmitted to OMB for review. As discussed above, this information is readily available on the www.reginfo.gov website. I understand that you have also written to Administrator Cass Sunstein of the Office of Information and Regulatory Affairs at OMB, who may have further comments on the issue of notifications. Of course, if there is a specific rule on which you would like a briefing after it has been put on display, please feel free to have your staff contact mine.

I am confident that the objectives discussed in your letter are shared equally by HHS staff. Rest assured that the Department is committed to a transparent regulatory process in order to maximize public input. My staff and I are more than willing to meet with you or your staff to discuss any specific concerns that you may have.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 16, 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman:

Thank you for your letter to President Obama regarding medical malpractice reform. He has asked me to respond on his behalf.

As the President noted in his State of the Union Address, the Administration strongly supports efforts to reduce health care costs, including considering ideas to rein in frivolous medical malpractice lawsuits. The President believes that we should consider reforms to our medical liability system to ensure that it improves the quality of care and patient safety, fairly and expeditiously compensates patients who are harmed by medical negligence, reduces liability premiums and the costs associated with defensive medicine, and weeds out frivolous lawsuits.

To that end, in 2009, the Administration established a $25 million initiative to support efforts by states and health systems to develop, implement, and evaluate patient safety and medical liability reforms. The Patient Safety and Medical Liability initiative is the most ambitious efforts to date by the Department of Health and Human Services (HHS) to support and evaluate state and health care system initiatives that address longstanding concerns about the medical liability system and patient safety. It is also the largest government investment connecting medical liability to quality and avoiding harm rather than just negligence and punishment. This initiative has funded seven three-year grants to support implementation and evaluation of patient safety and medical liability demonstrations, as well as thirteen one-year grants to plan and evaluate patient safety and medical liability initiatives. A comprehensive evaluation will assess findings from grants across the entire initiative.

The President's Fiscal Year 2012 Budget furthers the Administration's commitment by including $250 million in new grants to states to reform their medical liability laws. The Department of Justice, in consultation with HHS, would administer this program. The goal of these reforms would be to fairly compensate patients who are harmed by negligence, reduce providers' insurance premiums, weed out frivolous lawsuits, improve health care quality and patient safety, and reduce "defensive medicine" costs. States could propose reforms to their medical malpractice system through various approaches, such as health courts, safe harbors, early disclosure and offer, or other legal reforms.

The initiatives discussed above represent a substantial investment and commitment by this Administration in reforming our medical liability system. We greatly appreciate your willingness to explore further ways to address these concerns, and I offer the resources of my Department as you contemplate legislation. Should you have questions, please have your staff contact Jim Esquea, Assistant Secretary for Legislation, at (202) 690-7627. I will provide a similar response to the cosigners of your letter.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 13, 2011

The Honorable Daniel K. Inouye
United States Senate
Washington, D.C. 20510

Dear Senator Inouye:

Thank you for your letter regarding the Child Abuse Prevention and Treatment Reauthorization Act of 2010 (Public Law 111-320). You specifically inquired about a provision authorizing National Resource Centers focusing on the needs of Native Americans in states with high proportions of Indian, including Native Hawaiian and Alaska Native, children and their families.

As you know, the language in Public Law 111-320 requires the establishment of two National Resource Centers: (1) a National Resource Center on Domestic Violence; and (2) a National Indian Resource Center Addressing Domestic Violence and Safety for Indian Women.

The Administration for Children and Families in my Department currently fulfills this statutory requirement with the funding of a National Resource Center on Domestic Violence and the funding of a National Resource Center to End Violence Against Native Women, called Sacred Circle. The focus of Sacred Circle is on the development of community and culturally based responses to end violence against Native women, including Native Hawaiians and Alaska Natives. Enclosed is information about these two centers.

I hope this information is helpful to you. Please contact me if you have further thoughts or questions.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosure

FVPSA
FAMILY VIOLENCE AND PREVENTION SERVICES PROGRAM

Department of Health and Human Services / Administration for Children and Families
Administration on Children, Youth and Families / Family and Youth Services Bureau

nrc
National Resource Center on Domestic Violence

National Resource Center on Domestic Violence
800-537-2238
www.nrcdv.org and www.vawnet.org

The National Resource Center on Domestic Violence (NRCDV), a project of the Pennsylvania Coalition Against Domestic Violence, provides a wide range of free, comprehensive and individualized technical assistance, training and resource materials. The scope of NRCDV's technical assistance is broad and includes domestic violence intervention and prevention, community education and organizing, public policy and systems advocacy, and funding. The NRCDV develops information packets, fact sheets, applied research papers, funding alerts, and training curricula, and supports several special projects designed to explore issues more deeply or develop more comprehensive assistance to a particular constituent group. These special projects include the Domestic Violence Awareness Project, VAWnet – the National Online Resource Center on Violence Against Women (funded by CDC), the Women of Color Network, Building Comprehensive Solutions to Domestic Violence, and the current Domestic Violence Non-Residential Services & Supports study (funded by the National Institute of Justice).

Sacred Circle addresses violence against Indian women in the context of unique historical, jurisdictional and cultural issues. Sacred Circle provides leadership in establishing a multi-faceted, systemic response to facilitate nonviolence in American Indian communities. Sacred Circle is a project of Cangleska, Inc., a tribally-chartered nonprofit organization that provides domestic violence services to the Oglala Sioux Tribe in South Dakota. Sacred Circle's primary audience includes more than 500 Federally-recognized American Indian nations in the United Sates. Sacred Circle's main focus is to organize and establish a resource center serving domestic violence and sexual assault advocacy programs and other entities seeking resources to end violence against indigenous women. Sacred Circle's goals are (1) to increase Indian Nations' capacity to provide direct services and advocacy to women and their children victimized by battering and sexual assault through technical assistance, model programming, training and information that is culturally relevant; (2) to enhance tribes' and tribal organizations' creation of coordinated community response efforts, including advocacy and shelter programs, criminal justice, law enforcement and other related systems; and (3) to enhance tribal justice system's ability to provide for victim safety and batterer accountability through analysis and development of models for codes, policies, procedures and protocols.

SACRED CIRCLE
NATIONAL RESOURCE CENTER TO END VIOLENCE AGAINST NATIVE WOMEN

Sacred Circle:
National Resource Center to End Violence Against Native Women
877-733-7623
www.sacred-circle.com

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 14, 2010

The Honorable Charles E. Grassley
United States Senate
Washington, DC 20510

Dear Senator Grassley:

Thank you for your letter expressing concern about health care providers "upcoding" in the Medicare and Medicaid programs. I share your concern about this problem, and as noted in recent communications with your office, I can assure you that the Centers for Medicare & Medicaid Services (CMS) remains actively engaged in combatting all forms of fraud, waste and abuse.

As you are aware, upcoding has been a problem for some time now, for both private and government health insurance programs. In the Medicare program, this type of aberrant billing behavior is initially addressed by the Medicare Administrative Contractors (MACs), the claims processors who are the first line of defense in ensuring that Medicare payments are appropriate. The MACs utilize a variety of data analysis and medical review tools to identify when a provider may be upcoding claims or engaging in other abusive billing practices. In addition to taking action to ensure that the claims are processed and paid correctly, the MACs also provide education and technical assistance to offending providers to help them correct their behavior.

If education and technical assistance are not effective and a pattern of aberrant billing behavior persists, MACS may refer a case of suspected fraud to Zone Program Integrity Contractors (ZPICs) or Program Safeguard Contractors (PSCs) for further investigation. ZPICs and PSCs further develop cases and, when appropriate, may refer cases to the Office of Inspector General, Federal Bureau of Investigation or other appropriate law enforcement agencies.

As requested, each of your specific questions is restated below and followed by CMS' response:

1) **I am aware that plaintiff, Dr. Alan Gravett, has been communicating since August 2010, if not earlier, with CMS regarding his concerns about upcoding. When was CMS first informed of potential upcoding problems related to billing software?**

The Center for Program Integrity (CPI), the CMS office with primary responsibility for fraud, waste and abuse detection and prevention, has no record of being contacted by Dr. Gravett, and was unable to confirm any contacts that Dr. Gravett has had with other CMS offices. CMS was, however, recently provided with an informational copy of a letter on this issue that Dr. Gravett directed to the Senate, the House of Representatives and the Department of Justice. CMS will follow up, as appropriate.

2) **Provide a list of all software programs manufactured by health information technology companies where CMS has heard concerns about the possibility of upcoding. In responding, please provide a description of the concern CMS has with the software, how CMS became concerned with the software, the date CMS was first informed of concerns with the software, and what, if any, action CMS has taken to contain and prevent potential loss to Medicare and Medicaid because of problems with the software.**

The CMS program integrity activities focus on the providers that bill the Medicare and Medicaid programs, rather than the specific software programs that a provider uses. Therefore, CPI does not maintain a list of software packages suspected of containing "upcoding" capabilities.

3) **Has CMS made any efforts to identify the extent to which health care providers receiving Medicare and/or Medicaid reimbursements use allegedly problematic software for patient treatment and charting?**

As noted below, CMS has numerous programs and initiatives in place to address aberrant billing behaviors by providers. However, it is the responsibility of physicians, suppliers and other providers to submit accurate claims and to ensure that the billing software is accurately processing their claims.

4) **Has CMS taken any actions over the last two years to address issues involving questionable or fraudulent Medicare or Medicaid billing due to upcoding?**

As noted above, the MACs, as part of their claims processing activities, perform data analysis and medical review activities to identify questionable or fraudulent activity. Also, CMS' ZPICs and PSCs routinely perform medical reviews and proactive data analyses to detect aberrant billing practices of Medicare providers. The ZPICs, PSCs and MACs coordinate these efforts to ensure that appropriate administrative action is taken when questionable activity is identified and to ensure that referrals are made to law enforcement when fraud is suspected.

CMS Comprehensive Error Rate Testing (CERT) program includes a rigorous set of data that CMS can use to identify and prevent errors and educate providers that bill CMS programs. CMS continues to undertake aggressive efforts to lower the paid claims error rate. These efforts include the development of comparative billing reports to analyze administrative claims data, increased educational efforts with individual providers who have an unusual number of billing errors, revisions to Medicare fee-for-service manuals to clarify requirements for reviewing documentation to promote uniform interpretation of our policies, and development of new data analysis procedures to help identify payment aberrations. In addition to the CERT program, the Medicare Recovery Audit Contractor (RAC) program has effectively identified and corrected improper payments. As of September 30, 2010, the RAC program has recovered $75.5 million in FY 2010.

5) **Has CMS or any of its contractors performed an audit, evaluation, investigation or any other review of the Medicare and Medicaid billing process during the previous year to identify potential upcoding? If not, why not?**

CMS reviews data across its fee-for-service programs to help prevent improper payments, including payments made when providers have upcoded. CMS is also piloting new data analysis

approaches designed to identify and detect trends of improper payment activity, including geographic mapping based on fraud reported to 1-800 MEDICARE, and predictive modeling techniques that will be used to identify high-risk claims for further review prior to payment.

With respect to Medicaid, in FY 2010, CMS initiated Medicaid provider audits in all 10 CMS regions and also conducted 17 comprehensive state program integrity reviews. The Payment Error Rate Measurement program tracks improper payments in the Medicaid program and CMS has initiated state collaboration projects aimed at reducing improper Medicaid payments.

6) **What is the Department of Health and Human Services doing to ensure that CMS effectively oversees and manages its reimbursement to health care providers to prevent fraud, waste, and abuse in Medicare and Medicaid billing?**

Combating fraud, waste and abuse in the Medicare and Medicaid programs is among the Department of Health and Human Services' highest priorities, and HHS continues to strengthen its efforts in this area. In the Medicare program, CMS accomplishes this through the use of proactive data analysis, medical record review, investigations of complaints from various sources, on-site visits to providers, and beneficiary and provider interviews. Provider enrollment initiatives serve to ensure that only eligible providers and suppliers that meet the Medicare enrollment criteria are able to bill the program. These initiatives prevent providers and suppliers who have previously engaged in fraudulent activities from program entry, while also helping to ensure the quality of services provided to Medicare beneficiaries. CMS benefit integrity activities focus on the identification, detection and prevention of fraud and abuse in the Medicare program. Program trends are constantly monitored and CMS ZPICs and PSCs utilize administrative actions such as prepayment claims reviews and payment suspension, in addition to investigating fraud allegations and developing cases for referral to law enforcement.

Similar Medicaid program integrity efforts are in place, and CMS continues to provide support and assistance to states to combat Medicaid fraud. For example, the Medicaid Integrity Group (MIG) developed a national Medicaid claims database known as the MIG Data Engine. CMS and its contractors access the MIG Data Engine to identify aberrant billing patterns and support the audits of MIG's provider audit contractors. Also, many ZPICs and PSCs currently have agreements with state Medicaid programs to match provider data to identify providers that may be fraudulently billing both programs.

Thank you for your continued interest in safeguarding the Medicare and Medicaid programs from fraud, waste and abuse.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 19, 2011

The Honorable Herb Kohl
Chairman
Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Chairman Kohl:

Thank you for your letter regarding the detection of cognitive impairment as part of the new Medicare Annual Wellness Visit benefit. I understand your concern that this new benefit could lead to an increase in the number of cases of inappropriate treatment of seniors with Alzheimer's disease and agree that we need better screening tools and more effective management strategies to assist individuals with cognitive impairment.

As you noted, the April 2010 National Institutes of Health (NIH) State of the Science Conference on Preventing Alzheimer's Disease and Cognitive Decline raised concerns about the lack of effective interventions to delay the onset of Alzheimer's disease. However, you may be interested to know that a growing body of evidence from research and practice suggests that early intervention can positively affect the course of the disease and the individual's and family's ability to cope over time. For example, early detection and diagnosis, combined with counseling, planning assistance, and social engagement, may help sustain cognitive function and well-being, and it can also reduce excess disability and premature decline. In addition, early detection provides people in the early stages of dementia with the opportunity to plan their care and make decisions with their families about how their disease will be managed and their care preferences.

You ask a number of important questions that are responded to in the attached document. The Department will continue to monitor the progress of ongoing research on screening, diagnosis and treatment of Alzheimer's disease as well as its implications for Medicare annual wellness visits. Thank you again for raising this important issue with me. I hope this information is helpful and look forward to working with you to improve the quality of care for all Americans with cognitive impairments.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosure

Enclosure:

1. Is HHS providing guidance to physicians and other qualified practitioners on those screening tests that are considered to be the most reliable and accurate? Has the Department projected the number of false positive results for Alzheimer's disease that may be generated by wellness visits, if those screening methods are used, and how much their subsequent diagnostic tests and other follow-up services will cost?

HHS is developing guidance on appropriate screening tests. You may be interested to note that the U.S. Preventive Services Task Force (USPSTF), which is supported by the Agency for Healthcare Research and Quality (AHRQ), has reviewed the evidence for Mini-Mental Status Examinations (MMSEs) and determined that when this test is used to screen unselected patients, the predictive value of a positive result is fair. This USPSTF recommendation is available at http://www.uspreventiveservicestaskforce.org/3rduspstf/dementia/dementrr.pdf. The performance of other cognitive screening tests in a primary care setting is unclear at this time. Representatives from various HHS agencies, including NIH, AHRQ, the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), and the Department of Veterans Affairs, met in February 2011 to discuss the assessment of cognitive impairment and make recommendations regarding screening measures that can be used in the Medicare annual wellness visit. At this time, the Department has not projected costs or the number of false positive results since the numbers would vary depending on the type of test used and the extent to which the new benefit is utilized.

2. Has the Department projected how many Medicare beneficiaries will be accurately identified as having dementia through the wellness visit? Does it have plans to monitor how many Medicare beneficiaries will receive medications described in the NIH consensus panel review as lacking clear evidence of effectiveness, and the costs of these medications?

The Department has not projected how many beneficiaries will be accurately identified as having dementia since projections are difficult to make due to the varying effectiveness of screening tools and the lack of information on how many individuals will have an annual wellness visit. HHS officials share your belief that non-pharmacological interventions can be more beneficial and cause fewer adverse events in patients with Alzheimer's disease, but it is difficult to determine whether medications are used for prevention rather than for treatment of Alzheimer's. In addition, the simple presence of cognitive impairment, mild or otherwise, is not an indication for use of an antipsychotic medication of any kind. It seems unlikely that most physicians prescribe these medications simply because of cognitive impairment and, therefore, we do not expect the use of antipsychotic medications to increase greatly as a result of screening performed during the annual wellness visit.

3. If physicians and other practitioners seek training on proper screening and counseling techniques, how will the Department ensure that this training is both available and unbiased by commercial interests?

As with most continuing medical education, objective programs and courses are available through academic centers and professional societies. The Department encourages all health care

providers to take advantage of these opportunities for continued learning. In addition, the Administration on Aging (AoA), through its administration of the Alzheimer's Disease Supportive Services program (ADSSP), has funded cooperative agreements with several states that are piloting efforts that engage professionals who are providing services to persons with early-stage dementia and their families. These programs engage physicians to improve care coordination and planning with people in the early stages of dementia and their families.

4. Has HHS attempted to identify and/or encourage the development of services that are appropriate for managing early stages of Alzheimer's disease and other forms of dementia? If so, how will HHS make these strategies available to practitioners and the public?

As noted in the NIH State of the Science Conference final statement, ongoing research is needed regarding the screening and early management of Alzheimer's disease and other forms of dementia. Public forums such as the April 2010 conference provide opportunities for public input and dissemination of best practices and most effective treatments and services. In addition, the AoA, through its administration of the ADSSP program, has funded cooperative agreements with several states that are piloting evidence-based and innovative efforts to deliver services and supports at the community-level to people with early-stage dementia and their family caregivers.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 23, 2010

The Honorable John Barrasso
Vice Chairman
Senate Committee on Indian Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your letter of September 30, 2010, requesting that the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) undertake a comprehensive investigation of potential substandard health care services and mismanagement in all facilities operated by the Indian Health Service (IHS). Acting OMB Director Jeffrey Zients asked that I convey to you our strong commitment to working with the Committee to address the longstanding challenges facing IHS. We agree that the issues identified by the Committee's investigation are serious and require immediate action whether they occurred in the Aberdeen Area, or any other IHS Area Office (Area). We are pleased to advise that HHS and Dr. Yvette Roubideaux, the IHS Director, have already taken significant steps to address many of the issues raised in the oversight hearing, "In Critical Condition: The Urgent Need to Reform Indian Health Service's Aberdeen Area." OMB and HHS are committed to supporting Dr. Roubideaux so that these problems are corrected.

Ensuring program integrity is integral to the Administration's mission of providing access to quality health care for all Americans, including the First Americans. I recently launched a Department-wide, comprehensive program integrity initiative. Elements of this unprecedented effort include: (a) establishing a Secretary's Council on Program Integrity comprised of the heads of all HHS staff and operating divisions; (b) developing uniform tools and metrics that our senior managers can use to monitor their programs' progress; and (c) leveraging the experiences of Office of the Inspector General, OMB, and the Government Accountability Office to identify mismanagement and other abuses and make recommendations to help ensure success in this effort.

In response to the Committee's announcement of its investigation into problems in the Aberdeen Area, the Council on Program Integrity established the Aberdeen Area Program Integrity Task Force. The Task Force is reviewing IHS policies and standards, as well as the problems identified by the Committee to ensure that: (a) proper policies and procedures are in place in the Aberdeen Area; and (b) those policies and procedures result in corrective actions that prevent problems and improve service in the Aberdeen Area. The Task Force's recommendations, which will be completed by early spring, will be used to help formulate reviews that IHS is conducting in all 12 IHS Areas, which are discussed below.

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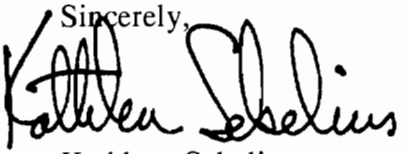
I want to assure the Committee that HHS and OMB are committed to supporting Dr. Roubideaux's efforts to change and improve the way the IHS does business, and the way its facilities provide health care. We will work cooperatively with IHS to identify problems and take corrective action with all deliberate speed. The Council on Program Integrity will work with Dr. Roubideaux to ensure these action plans are implemented and sustained.

Again, thank you for your letter. We are grateful for your commitment to ensuring that American Indians and Alaska Natives receive the highest quality health care.

Sincerely,



Kathleen Sebelius

Enclosures

cc: Jeffrey D. Zients
Acting Director
Office of Management and Budget
Dr. Yvette Roubideaux

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 23, 2010

The Honorable Al Franken
United States Senator
United States Senate
Washington, DC 20510

Dear Senator Franken:

Thank you for your letter of September 30, 2010, requesting that the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) undertake a comprehensive investigation of potential substandard health care services and mismanagement in all facilities operated by the Indian Health Service (IHS). Acting OMB Director Jeffrey Zients asked that I convey to you our strong commitment to working with the Committee to address the longstanding challenges facing IHS. We agree that the issues identified by the Committee's investigation are serious and require immediate action whether they occurred in the Aberdeen Area, or any other IHS Area Office (Area). We are pleased to advise that HHS and Dr. Yvette Roubideaux, the IHS Director, have already taken significant steps to address many of the issues raised in the oversight hearing, "In Critical Condition: The Urgent Need to Reform Indian Health Service's Aberdeen Area." OMB and HHS are committed to supporting Dr. Roubideaux so that these problems are corrected.

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Again, thank you for your letter. We are grateful for your commitment to ensuring that American Indians and Alaska Natives receive the highest quality health care.

Sincerely,

Kathleen Sebelius

Enclosures

cc: Jeffrey D. Zients
Acting Director
Office of Management and Budget
Dr. Yvette Roubideaux

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 23, 2010

The Honorable Tom Coburn
United States Senator
United States Senate
Washington, DC 20510

Dear Senator Coburn:

Thank you for your letter of September 30, 2010, requesting that the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) undertake a comprehensive investigation of potential substandard health care services and mismanagement in all facilities operated by the Indian Health Service (IHS). Acting OMB Director Jeffrey Zients asked that I convey to you our strong commitment to working with the Committee to address the longstanding challenges facing IHS. We agree that the issues identified by the Committee's investigation are serious and require immediate action whether they occurred in the Aberdeen Area, or any other IHS Area Office (Area). We are pleased to advise that HHS and Dr. Yvette Roubideaux, the IHS Director, have already taken significant steps to address many of the issues raised in the oversight hearing, "In Critical Condition: The Urgent Need to Reform Indian Health Service's Aberdeen Area." OMB and HHS are committed to supporting Dr. Roubideaux so that these problems are corrected.

Ensuring program integrity is integral to the Administration's mission of providing access to quality health care for all Americans, including the First Americans. I recently launched a Department-wide, comprehensive program integrity initiative. Elements of this unprecedented effort include: (a) establishing a Secretary's Council on Program Integrity comprised of the heads of all HHS staff and operating divisions; (b) developing uniform tools and metrics that our senior managers can use to monitor their programs' progress; and (c) leveraging the experiences of Office of the Inspector General, OMB, and the Government Accountability Office to identify mismanagement and other abuses and make recommendations to help ensure success in this effort.

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d. Develop a timetable for reviewing all IHS-operated facilities with a focus on identifying and reviewing the highest risk facilities first.

I want to assure the Committee that HHS and OMB are committed to supporting Dr. Roubideaux's efforts to change and improve the way the IHS does business, and the way its facilities provide health care. We will work cooperatively with IHS to identify problems and take corrective action with all deliberate speed. The Council on Program Integrity will work with Dr. Roubideaux to ensure these action plans are implemented and sustained.

Again, thank you for your letter. We are grateful for your commitment to ensuring that American Indians and Alaska Natives receive the highest quality health care.

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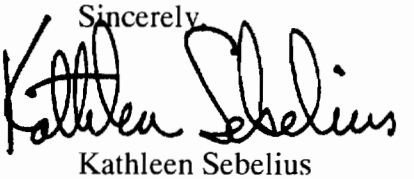

Kathleen Sebelius

Enclosures

cc: Jeffrey D. Zients
Acting Director
Office of Management and Budget
Dr. Yvette Roubideaux

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 23, 2010

The Honorable Byron L. Dorgan
Chairman
Committee on Indian Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your letter of September 30, 2010, requesting that the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) undertake a comprehensive investigation of potential substandard health care services and mismanagement in all facilities operated by the Indian Health Service (IHS). Acting OMB Director Jeffrey Zients asked that I convey to you our strong commitment to working with the Committee to address the longstanding challenges facing IHS. We agree that the issues identified by the Committee's investigation are serious and require immediate action whether they occurred in the Aberdeen Area, or any other IHS Area Office (Area). We are pleased to advise that HHS and Dr. Yvette Roubideaux, the IHS Director, have already taken significant steps to address many of the issues raised in the oversight hearing, "In Critical Condition: The Urgent Need to Reform Indian Health Service's Aberdeen Area." OMB and HHS are committed to supporting Dr. Roubideaux so that these problems are corrected.

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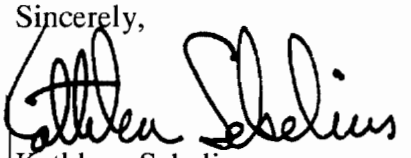

Kathleen Sebelius

Enclosures

cc: Jeffrey D. Zients
Acting Director
Office of Management and Budget
Dr. Yvette Roubideaux

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 23, 2010

The Honorable Daniel K. Inouye
United States Senator
United States Senate
Washington, DC 20510

Dear Senator Inouye:

Thank you for your letter of September 30, 2010, requesting that the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) undertake a comprehensive investigation of potential substandard health care services and mismanagement in all facilities operated by the Indian Health Service (IHS). Acting OMB Director Jeffrey Zients asked that I convey to you our strong commitment to working with the Committee to address the longstanding challenges facing IHS. We agree that the issues identified by the Committee's investigation are serious and require immediate action whether they occurred in the Aberdeen Area, or any other IHS Area Office (Area). We are pleased to advise that HHS and Dr. Yvette Roubideaux, the IHS Director, have already taken significant steps to address many of the issues raised in the oversight hearing, "In Critical Condition: The Urgent Need to Reform Indian Health Service's Aberdeen Area." OMB and HHS are committed to supporting Dr. Roubideaux so that these problems are corrected.

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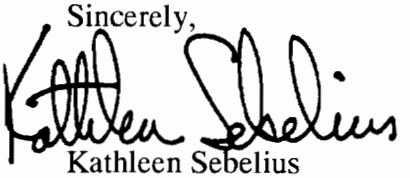


Kathleen Sebelius

Enclosures

cc: Jeffrey D. Zients
Acting Director
Office of Management and Budget
Dr. Yvette Roubideaux

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

September 14, 2010

The Honorable James L. Oberstar
Chairman
Committee on Transportation and Infrastructure
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter inquiring about alleged actions by Enbridge, Inc., to mislead or coerce individuals who live near the recent pipeline oil spill in Marshall, Michigan, to sign broad authorizations for the release of their medical records. I, too, am deeply concerned about these allegations, which, if true, are offensive to the privacy rights of these individuals.

On September 7, 2010, I called on Enbridge to cease any such practices immediately and to provide me with further information on this matter. We also are working with health care providers to inform Michigan residents of their rights under the Health Insurance Portability and Accountability Act (HIPAA) not to be coerced into signing such an authorization in exchange for treatment and, if they do sign an authorization, of their right to revoke it at any time. Moreover, we are working with other agencies and exploring every legal avenue to protect the privacy interests of these individuals.

Thank you again for alerting me to this important issue. I have enclosed a copy of my letter to Enbridge and the fact sheet we have prepared to inform affected individuals of their HIPAA privacy rights in this situation. I will also provide this response to Congressman Schauer. Please feel free to contact me with any further questions or concerns.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosures

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

September 7, 2010

Mr. Patrick D. Daniel
President and Chief Executive Officer
Enbridge, Inc.
3000 Fifth Avenue Place
425 1st Street SW
Calgary, Alberta
T2P 3L8 Canada

Dear Mr. Daniel:

I am writing regarding reports that your company, Enbridge, Inc., has misled and/or coerced individuals whose health may have been affected by the recent oil spill in Marshall, Michigan.

Specifically, I have been advised that Enbridge may have misled or coerced individuals to sign forms authorizing the release of personal medical records to Enbridge upon referral to a local family health center; that these forms authorize the disclosure of an inappropriately broad amount of medical information, including information wholly unrelated to their current conditions or complaints; that the form could be directed to any provider, not only the one(s) to which the patient has sought treatment for the potentially oil spill-related condition; and that Enbridge has failed to adequately inform these individuals of their privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). If these reports are true, the company's actions are a deplorable affront to patients' privacy rights, and I call on you to cease these practices immediately.

One way HIPAA protects the privacy and security of individuals' health information is by requiring a HIPAA-compliant authorization for health care providers and certain other entities to disclose that information. HIPAA requires that authorizations be easy to understand, and contain specific information, including the information to be disclosed, the entities disclosing and receiving the information, the expiration date of the authorization, and the individual's right to revoke the authorization.

A health care provider may not coerce an individual into signing a HIPAA-compliant authorization in exchange for treatment, and an individual may revoke an authorization in writing at any time. In addition, providers in this situation may not deny treatment to individuals because they refuse to sign a HIPAA authorization.

As you know, the U.S. House of Representatives' Committee on Transportation and Infrastructure is currently investigating this matter. Chairman Oberstar and Representative Schauer have requested that the Department of Health and Human Services (HHS) make inquiries of its own. Please provide copies of all Enbridge medical release forms used in relation to the oil spill and an explanation of their extraordinary scope. I would also appreciate learning

of the means by which you are advising affected Michigan residents of their ability to receive treatment in this situation even if they do not sign a release.

HHS is prepared to work with other federal agencies as well as state and local officials to explore every legal avenue to ensure patients' privacy interests are protected. We also intend to work with health care providers to inform Michigan residents that, in this situation, their ability to receive treatment may not be made contingent on their signing a HIPAA authorization, and that, if they do sign an authorization, they may revoke it at any time. I expect your company to take immediate steps to respect the privacy rights of individuals seeking treatment.

Sincerely,

Kathleen Sebelius

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

THE ENBRIDGE OIL SPILL AND YOUR RIGHT TO MEDICAL PRIVACY UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The U.S. Department of Health and Human Services has recently become aware of reports that Enbridge, Inc., may have misled or coerced individuals whose health was potentially affected by the recent oil spill in Marshall, Michigan, to sign forms authorizing the broad release of medical records to Enbridge upon referral to a local family health center.

The Health Insurance Portability and Accountability Act (HIPAA) protects the privacy and security of individuals' health information in certain ways and provides individuals with certain rights with respect to their health information. If you believe your health may have been affected by the recent oil spill, you should be aware of the following rights afforded to you by HIPAA:

- Under HIPAA, health care providers may disclose your health information so they can be paid for their services, but they may only disclose the minimum amount of information needed for this purpose.
- HIPAA also permits health care providers and certain other entities to disclose your health information for treatment and other specified purposes such as public health, but a signed, HIPAA-compliant authorization is otherwise required for use or disclosure of your information.
- HIPAA requires such authorizations be in plain language, and contain specific information regarding:
    - the information to be disclosed;
    - the entities disclosing and receiving the information;
    - the expiration date of the authorization;
    - your right to revoke the authorization;
    - the ability or inability to condition treatment on the authorization; and
    - the potential for information to be re-disclosed.
- You may not be coerced into signing a HIPAA authorization in exchange for treatment.
- You may amend a written authorization to limit its scope. (If you believe the authorization is too broad, you may strike certain portions or rewrite it.)
- You may revoke an authorization in writing at any time.
- A health care provider may not deny you treatment because you have not signed a HIPAA-compliant authorization unless the treatment is research-related, the treatment is solely to prepare a report for a third party, or a health plan needs information for enrollment purposes.

If you have any questions about your rights with respect to the release of your personal medical information, please contact Andra Wicks of the HHS Office for Civil Rights at andra.wicks@hhs.gov or 202-205-2292.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 22, 2010

The Honorable Herb Kohl
Chairman, Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Chairman Kohl:

Thank you for your letter expressing support for the Administration's strong commitment to funding programs and policies that promote the health and well-being of older Americans through primary care. As you know, the need for geriatric care is increasing, and is expected to peak in 2030.

The responses to your six questions regarding the pressing need to train and educate current and pipeline providers in the interdisciplinary care of geriatric patients are enclosed.

I appreciate your support for our programs and your commitment to meeting the health workforce needs of the nation's rapidly aging society. Please do not hesitate to contact me if you have any further thoughts or questions.

Sincerely,

Kathleen Sebelius

Enclosure

Responses to the Special Committee on Aging

(1) Of the $250 million increase for health workforce enhancements, as proposed in the Department's FY 2011 budget amendments recently transmitted to Congress, how much is to be used for Title VII geriatrics health professions programs and Title VIII geriatrics nursing programs? Please provide funding details, including specific amounts for each program.

A total of $20 million will be used for geriatric programs authorized by Title VII; $16 million for Geriatric Education Centers and $4 million for the Geriatric Academic Career Awards program. We plan to fund approximately 15 new Geriatric Education Centers which reach a broad range of health professionals and provide them with the knowledge and skills necessary to address the health issues of older Americans. The funding of Geriatric Academic Career Awards will support the training of 40 additional geriatricians who will be able to provide needed services as well as provide training. These grants will fully fund the five year grant project periods.

(2) Of the 16,000 new primary care providers that HHS expects will be trained using PPACA funds during the next five years, what is the estimated number that will receive specific training in geriatrics to ensure that they have the skills, knowledge and experience to meet the more complex needs of older adults?

The 16,000 new primary care providers will be produced using PPACA funds through Titles VII and VIII programs as well as through the National Health Service Corps; the total number of providers that will be trained using PPACA funds is expected to be much higher. While HRSA strongly encourages all training programs to include specific training in geriatrics, it is difficult to estimate which of these providers will receive training in geriatrics.

(3) Given the urgent need to increase the number of geriatrics faculty at medical schools and health professions schools across the country, is additional funding being made available for the GACA program in FY 2010 and FY 2011 and in the Department's budget request for FY 2012? For example, due to the increased number of applications from newly-eligible disciplines as provided under PPACA, it has become clear that there is a need for a higher level of funding for GACA awards. Accordingly, what steps can you take to ensure that some portion of the increases for healthcare workforce enhancement activities, as proposed in the Department's Fiscal Year 2011 budget amendment, will be directed to the GACA program?

The Administration has recognized the importance of enhancing the GACA program, especially in light of newly-eligible disciplines that will accordingly increase the applicant pool. Because of this recognized need, the FY 2011 Amended President's Budget provides that $9,238,174 be put towards GACA. This is an increase of $4,000,000 compared to FY 2010. This increase will provide assistance for physicians and other health professionals planning to teach in the fields of geriatric medicine, nursing, dentistry, and behavioral and mental health. The FY 2012 President's Budget has not yet been finalized.

(4) The Department's recent inclusion of geriatricians, as well as nurse practitioners and physician assistants specializing in geriatrics, for eligibility under the National Health Service Corps (NHSC) is a welcome and appropriate recognition of their role as primary care providers. We are aware, however, that very few geriatricians have been accepted to date into the Corps, and would like to know what affirmative steps the Department is taking to increase the number of applicants. For example, has HHS engaged medical schools and other health professions schools, as well as relevant professional associations, in outreach efforts and to provide technical assistance?

The National Health Service Corps is using a number of outreach methods to increase awareness and understanding among each of the clinical disciplines and specialties eligible for the Corps, including one of the newest, geriatrics. For example, we are identifying key professional associations such as The American Geriatrics Society, Gerontological Association of America, American Medical Directors Association, the American Society on Aging and others who serve as trusted sources and key points of information dissemination for geriatricians. We work with these groups to identify opportunities for information distribution about the Corps through their publications and websites, conferences (national and regional), speaking opportunities and special events. In addition, the Corps has relationships with associations that reach into medical schools (e.g., Association of American Medical Colleges) and individuals at medical schools with strong geriatric programs (e.g., Johns Hopkins, Duke University Medical Center, University of Michigan). Representatives at those schools are asked to conduct a range of activities to promote opportunities available through the NHSC by hosting brown bag information sessions, posting materials about the Corps within the schools, and other activities appropriate for the individual institution. Finally, we continue to explore opportunities to publish articles and information in newsletters and journals consumed by geriatricians.

(5) Does the Department intend to expand the scope of all applicable PHSA primary care grant programs to encompass geriatricians and other geriatrics health professionals?

Within Sec. 5301 of the Affordable Care Act, titled Enhancing Health Care Workforce Education and Training, the specific language obliges the Department to give special priority to awards in primary care capacity building to those applicants that provide training in the care of vulnerable populations, including the elderly. The Department is working in conjunction with professional organizations and stakeholders, such as family doctors and nursing groups, to ensure that geriatrics is considered when implementing primary care grant programs.

(6) Finally, what additional actions is the Department taking to address the shortage of faculty to train and educate the geriatrics primary care providers who will be caring for elderly patients?

The Department recognizes that there is still substantial need for faculty with the expertise to train and educate the future geriatric workforce. In response to this recognized need, programs under PHSA Sec. 753 include Geriatric Faculty Fellowships for geriatric professionals in internal medicine, family practice, psychiatry or licensed dentistry, who may receive fellowships for training students in clinical geriatrics programs. Additionally, Geriatric Workforce Development is a new program under ACA that incentivizes the geriatric training of faculty members of medical and other health professions schools through fellowships. The fellowship offers intensive training in geriatrics to faculty members focused on primary care medicine, nursing, dentistry and allied health programs, with the goal of enhancing their interdisciplinary teaching skills. In addition to these programs, the National Center for Health Care Workforce Analysis will provide the critical data necessary to assess accurately the needs of our health care workforce, in an effort to identify continued shortages of faculty trained and educated in geriatrics.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

July 16, 2010

The Honorable Arlen Specter
United States Senate
Washington, D.C. 20510

Dear Senator Specter:

Thank you for your letter in which you inquire about plans for the Centers for Disease Control and Prevention (CDC) to reprogram polycythemia vera (PV) cluster funding in fiscal year (FY) 2010.

CDC and the Department of Health and Human Services are in the process of finalizing a budget realignment (consistent with the new organizational structure) and reallocation package for FY 2010. The package, which is still being developed, realigns the budget to the organizational structure and provides a greater emphasis on key priority areas—including strengthening surveillance, epidemiology, data collection, infrastructure, and global health activities—and support for state and local public health. Throughout this process, CDC considered a number of options for reallocating resources. Please note that CDC does plan to continue funding the PV cancer cluster in FY 2010. Any changes to the PV-appropriated level will be minimal and will have little to no impact on programmatic activities.

As you are already aware, CDC has been engaged with the local community in examining the incidence of PV in the Carbon, Luzerne, Schuylkill tri-county area. On May 11, 2010, CDC released a final report regarding the Community Health Screening for the JAK2 genetic marker. Following two rounds of community health screening in northeastern Pennsylvania for the JAK2 genetic marker, 19 (1.6%) of the 1,170 persons tested were found to have this mutation. Five persons were previously diagnosed with PV or with a similar blood disease.

Since the JAK2 genetic marker was identified in 2004, studies have shown that this mutation is present in approximately 95 percent of patients with PV. Scientists also do not know how prevalent the mutation is in the general population, or whether everyone who has the mutation will develop PV or a related blood disease. To help answer these questions, CDC is funding studies at the Pennsylvania Department of Health, Drexel University, University of Pittsburgh, Mount Sinai Medical Center, Geisinger Health System, and internally to investigate PV and other Myeloproliferative neoplasms (MPN) in the tri-county area.

In FY 2010, CDC will support the following three studies that will provide additional information on the prevalence rate of JAK2 mutations.

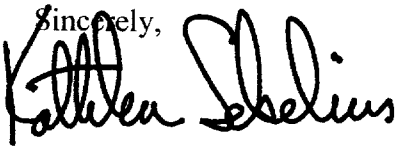
1. Geisinger Health Systems will screen a random sample of 2,500 people from the PV cluster area for the JAK2 mutation.

2. Geisinger Health Systems will screen 6,000 participants from outside the tri-county area to determine the "background" prevalence of the JAK2 mutation in Pennsylvania.

3. CDC has submitted a proposal to determine the prevalence of the JAK2 mutation in the 1999-2002 NHANES DNA sample set (7,900 samples). This will reflect the national "background" prevalence.

Thank you again for your letter. If you need further information, please contact Henry Falk, M.D., M.P.H., Acting Director, CDC's National Center for Environmental Health/Agency for Toxic Substances and Disease Registry, at (770) 488-0608 or at HFalk@cdc.gov. We appreciate your support to better understand the prevalence and potential causes of PV, related MPNs, and JAK2 mutation.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Debbie Stabenow
United States Senate
Washington, DC 20510

Dear Senator Stabenow:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

As your letter noted, the Balanced Budget Act (BBA) of 1997 established a cap on the number of residents a hospital may count for purposes of Medicare GME payments based on the number of full-time equivalent (FTE) residents it was training in its most recent cost reporting period ending on or before December 31, 1996. The regulations at 42 CFR 413.79(e)(1) implemented by the Centers for Medicare & Medicaid Services (CMS) state that if a hospital had no allopathic or osteopathic residents in that base year, the hospital may receive an adjustment to its FTE resident cap of zero if it establishes a "new" medical residency training program.

The regulations at 42 CFR 413.79(l) define a new medical residency training program as "a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." In the August 29, 1997, Inpatient Prospective Payment System (IPPS) final rule, CMS (then the Health Care Financing Administration) discussed both the meaning of a new residency training program and the rationale for establishing this definition:

> For purposes of this provision, a "program" will be considered newly established if it is accredited for the first time, including provisional accreditation on or after January 1, 1995, by the accrediting body. Although the Secretary has broad authority to prescribe rules for counting residents in new programs, the Conference Report for P.L. 105-33 indicates concern that aggregate number of FTE residents should not increase over current levels (62 FR 46006, August 29, 1997).

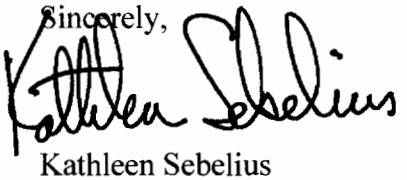
Similarly, in the July 30, 1999, final rule, CMS responded to a public comment suggesting that the Agency include within the definition of "new residency program" a program that may have existed previously at other clinical sites. CMS replied that the phrase "begins training residents on or after January 1, 1995," means that the program may have been accredited by the appropriate accrediting body prior to January 1, 1995, but did not begin training in the program until on or after January 1, 1995. In other words, this language would not permit a program to be considered new if the program operated at another hospital prior to January 1, 1995, as the commenter suggests (64 FR 41519, July 30, 1999).

Accordingly, CMS believes it is appropriate to evaluate whether a program is truly new, as opposed to an existing program that is re-located to a new site, in order to determine whether the program qualifies for Medicare GME payments. CMS generally considers supporting factors such as whether there are new program directors, new teaching staff, and new residents in a program operating at a new site. These sorts of deliberate determinations are necessary because the Conference Report cited in the 1997 final rule explicitly states that Congress' policy objective is to limit the aggregate number of FTE residents to the "current" levels at the time the BBA was enacted in 1997.

We have received a number of inquiries suggesting that Medicare's policy had previously been to consider a GME program "new" based solely on a letter from the Accreditation Council for Graduate Medical Education (ACGME) indicating initial accreditation. However, CMS has been applying the criteria outlined above, consistent with its statements in the 1997 and 1999 regulations, for many years. In response to these inquiries, CMS further clarified in the FY 2010 IPPS proposed and final rules that a variety of factors, and not just a letter from the ACGME, will be used to determine whether a program is new or a transfer of an existing program to a new site.

I am happy to have my staff work with you on this important issue. I appreciate your interest in this issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Gary Peters
U.S. House of Representatives
Washington, DC 20515

Dear Representative Peters:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

As your letter noted, the Balanced Budget Act (BBA) of 1997 established a cap on the number of residents a hospital may count for purposes of Medicare GME payments based on the number of full-time equivalent (FTE) residents it was training in its most recent cost reporting period ending on or before December 31, 1996. The regulations at 42 CFR 413.79(e)(1) implemented by the Centers for Medicare & Medicaid Services (CMS) state that if a hospital had no allopathic or osteopathic residents in that base year, the hospital may receive an adjustment to its FTE resident cap of zero if it establishes a "new" medical residency training program.

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I am happy to have my staff work with you on this important issue. I appreciate your interest in this issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

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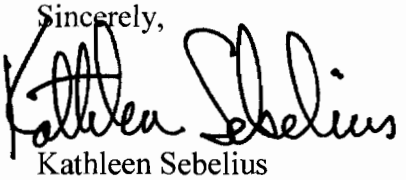

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable John Dingell
U.S. House of Representatives
Washington, DC 20515

Dear Representative Dingell:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

As your letter noted, the Balanced Budget Act (BBA) of 1997 established a cap on the number of residents a hospital may count for purposes of Medicare GME payments based on the number of full-time equivalent (FTE) residents it was training in its most recent cost reporting period ending on or before December 31, 1996. The regulations at 42 CFR 413.79(e)(1) implemented by the Centers for Medicare & Medicaid Services (CMS) state that if a hospital had no allopathic or osteopathic residents in that base year, the hospital may receive an adjustment to its FTE resident cap of zero if it establishes a "new" medical residency training program.

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We have received a number of inquiries suggesting that Medicare's policy had previously been to consider a GME program "new" based solely on a letter from the Accreditation Council for Graduate Medical Education (ACGME) indicating initial accreditation. However, CMS has been applying the criteria outlined above, consistent with its statements in the 1997 and 1999 regulations, for many years. In response to these inquiries, CMS further clarified in the FY 2010 IPPS proposed and final rules that a variety of factors, and not just a letter from the ACGME, will be used to determine whether a program is new or a transfer of an existing program to a new site.

I am happy to have my staff work with you on this important issue. I appreciate your interest in this issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

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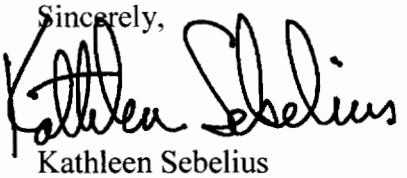

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Olympia Snowe
United States Senate
Washington, DC 20510

Dear Senator Snowe:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

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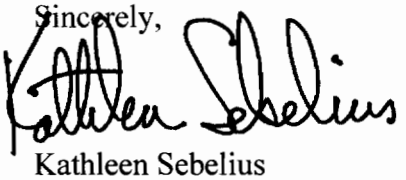

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Carl Levin
United States Senate
Washington, DC 20510

Dear Senator Levin:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

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I am happy to have my staff work with you on this important issue. I appreciate your interest in this issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

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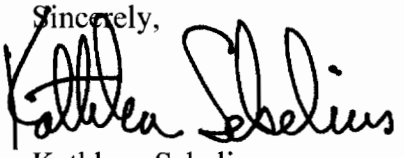

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Dale Kildee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kildee:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

As your letter noted, the Balanced Budget Act (BBA) of 1997 established a cap on the number of residents a hospital may count for purposes of Medicare GME payments based on the number of full-time equivalent (FTE) residents it was training in its most recent cost reporting period ending on or before December 31, 1996. The regulations at 42 CFR 413.79(e)(1) implemented by the Centers for Medicare & Medicaid Services (CMS) state that if a hospital had no allopathic or osteopathic residents in that base year, the hospital may receive an adjustment to its FTE resident cap of zero if it establishes a "new" medical residency training program.

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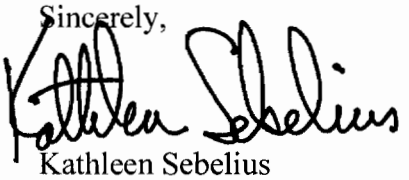

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Chellie Pingree
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pingree:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

As your letter noted, the Balanced Budget Act (BBA) of 1997 established a cap on the number of residents a hospital may count for purposes of Medicare GME payments based on the number of full-time equivalent (FTE) residents it was training in its most recent cost reporting period ending on or before December 31, 1996. The regulations at 42 CFR 413.79(e)(1) implemented by the Centers for Medicare & Medicaid Services (CMS) state that if a hospital had no allopathic or osteopathic residents in that base year, the hospital may receive an adjustment to its FTE resident cap of zero if it establishes a "new" medical residency training program.

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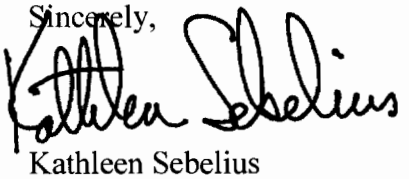

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Lamar Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

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Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Susan Collins
United States Senate
Washington, DC 20510

Dear Senator Collins:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

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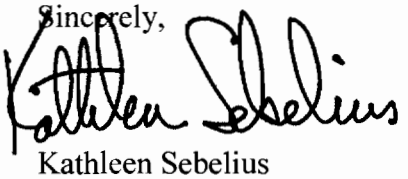

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Bill Nelson
United States Senate
Washington, DC 20510

Dear Senator Nelson:

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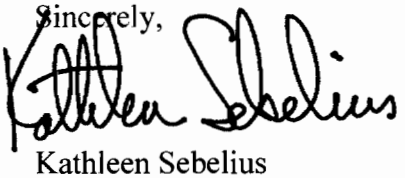

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Debbie Wasserman Schultz
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wasserman Schultz:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable Lloyd Doggett
U.S. House of Representatives
Washington, DC 20515

Dear Representative Doggett:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

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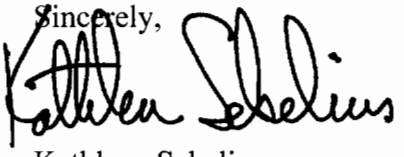
I am happy to have my staff work with you on this important issue. I appreciate your interest in this issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 30, 2010

The Honorable George LeMieux
U.S. House of Representatives
Washington, DC 20515

Dear Representative LeMieux:

Thank you for your letter regarding Medicare regulations that address whether a graduate medical education (GME) training program is considered a "new medical residency program" for purposes of direct GME and indirect medical education (IME) payments. I appreciate that you followed up on this issue after the February 3, 2010 hearing.

As your letter noted, the Balanced Budget Act (BBA) of 1997 established a cap on the number of residents a hospital may count for purposes of Medicare GME payments based on the number of full-time equivalent (FTE) residents it was training in its most recent cost reporting period ending on or before December 31, 1996. The regulations at 42 CFR 413.79(e)(1) implemented by the Centers for Medicare & Medicaid Services (CMS) state that if a hospital had no allopathic or osteopathic residents in that base year, the hospital may receive an adjustment to its FTE resident cap of zero if it establishes a "new" medical residency training program.

The regulations at 42 CFR 413.79(l) define a new medical residency training program as "a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." In the August 29, 1997, Inpatient Prospective Payment System (IPPS) final rule, CMS (then the Health Care Financing Administration) discussed both the meaning of a new residency training program and the rationale for establishing this definition:

> For purposes of this provision, a "program" will be considered newly established if it is accredited for the first time, including provisional accreditation on or after January 1, 1995, by the accrediting body. Although the Secretary has broad authority to prescribe rules for counting residents in new programs, the Conference Report for P.L. 105-33 indicates concern that aggregate number of FTE residents should not increase over current levels (62 FR 46006, August 29, 1997).

Similarly, in the July 30, 1999, final rule, CMS responded to a public comment suggesting that the Agency include within the definition of "new residency program" a program that may have existed previously at other clinical sites. CMS replied that the phrase "begins training residents on or after January 1, 1995," means that the program may have been accredited by the appropriate accrediting body prior to January 1, 1995, but did not begin training in the program until on or after January 1, 1995. In other words, this language would not permit a program to be considered new if the program operated at another hospital prior to January 1, 1995, as the commenter suggests (64 FR 41519, July 30, 1999).

Accordingly, CMS believes it is appropriate to evaluate whether a program is truly new, as opposed to an existing program that is re-located to a new site, in order to determine whether the program qualifies for Medicare GME payments. CMS generally considers supporting factors such as whether there are new program directors, new teaching staff, and new residents in a program operating at a new site. These sorts of deliberate determinations are necessary because the Conference Report cited in the 1997 final rule explicitly states that Congress' policy objective is to limit the aggregate number of FTE residents to the "current" levels at the time the BBA was enacted in 1997.

We have received a number of inquiries suggesting that Medicare's policy had previously been to consider a GME program "new" based solely on a letter from the Accreditation Council for Graduate Medical Education (ACGME) indicating initial accreditation. However, CMS has been applying the criteria outlined above, consistent with its statements in the 1997 and 1999 regulations, for many years. In response to these inquiries, CMS further clarified in the FY 2010 IPPS proposed and final rules that a variety of factors, and not just a letter from the ACGME, will be used to determine whether a program is new or a transfer of an existing program to a new site.

I am happy to have my staff work with you on this important issue. I appreciate your interest in this issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the cosigners of your letter.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 25, 2010

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510-6200

Dear Chairman Baucus:

Thank you for your letter requesting biannual reports that quantify the amount of fraud, waste, and abuse in Federal health care programs. I wanted to let you know that my staff has already been in touch with David Schwartz of your Finance Committee staff on several occasions to begin working on your request.

I share your strong commitment to rooting out wasteful and fraudulent spending, and to ensuring that federal programs use their resources as wisely as possible. Health care fraud and improper payments undermine the integrity of our public and private health care programs. As a result of such fraud, taxpayer dollars have been stolen, health care costs have risen, and, in some instances, patients have been endangered.

The Department of Health and Human Services (HHS) is working vigilantly to be the best steward of Federal health insurance programs and the taxpayer dollars that support them. In the past year, we have coordinated anti-fraud efforts across the government, and have begun to employ tougher standards in calculating improper payment rates. In addition to these efforts, we are prepared to make the long-term commitment that will be necessary to effectively combat these problems in the months and years ahead.

Again, thank you for your interest and attention to this important matter. We look forward to collaborating with you and your staff to ensure that the information that HHS collects and disseminates is useful as we work to create a more efficient and effective health care system.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

February 3, 2010

The Honorable Anna G. Eshoo
U.S. House of Representatives
Washington, D.C. 20515-0514

Dear Representative Eshoo:

Thank you for your inquiry in follow-up to the September 2009 Energy and Commerce Committee hearing on 2009-H1N1 influenza preparedness efforts. Please accept my sincere apology for the delay in my responses to your questions that are provided below.

- **Why did the Administration propose this funding transfer?**

On June 2, 2009, the Administration submitted a second supplemental appropriations request for funding to address 2009-H1N1 influenza. This supplemental request proposed expanding the use of the Project BioShield Special Reserve Fund to include procurement of medical countermeasures relating to emerging influenza viruses. The supplemental request proposed additional flexibility to transfer funding provided through the American Recovery and Reinvestment Act and other HHS appropriations to support 2009-H1N1 influenza-related activities. These proposals would have provided maximum flexibility to allow the Administration to target its response and resources as this emerging and unpredictable situation evolved. Congress did not provide these flexibilities when it appropriated $7.65 billion in new funding in the 2009 supplemental appropriations bill enacted on June 24, 2009.

- **Are there plans to consider using the SRF for this purpose in the future?**

No, there are no plans to use the Special Reserve Fund to support pandemic influenza preparedness efforts.

- **What do you believe is the appropriate funding level for BioShield and BARDA?**

The enactment of Project BioShield in 2004 enabled a market that had not existed – it provided a robust incentive for pharmaceutical and biotech companies, and essential authorities for government agencies, to facilitate product development and usage. Through BioShield, the Biomedical Advanced Research and Development Authority (BARDA), the central agency within the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) granted the authority to develop and acquire chemical, biological, radiological and nuclear (CBRN) medical countermeasures, has delivered six CBRN countermeasures to the Strategic National

Stockpile to date. In 2010, BARDA plans on using Project BioShield to acquire additional first-in-class countermeasures for the stockpile, such as smallpox antivirals and acute radiation sickness drugs, and to expand its anthrax and botulism antitoxin programs to enable long-term stockpile maintenance and surge capacity.

My FY 2011 budget includes a total of $476 million for BARDA to invest in promising medical countermeasures for high-priority threats, including anthrax, radiation, and enhanced agents. These funds will be provided by making Project BioShield funds available for both BioShield procurements and advanced research and development. The budget also provides the Secretary with the authority to make additional funds available for dual purposes 15 days after notification of Congress. Current Project BioShield balances total $1.8 billion.

I have asked my Assistant Secretary for Preparedness and Response to conduct a medical countermeasures review, which would include an end-to-end review of medical countermeasure development across HHS, including activities funded through Project BioShield and BARDA. This report is due by March 31, 2010. HHS and key U.S. Government stakeholders are currently undertaking this comprehensive internal review of the CBRN medical countermeasures enterprise with the goal of developing a more comprehensive, integrated, and holistic strategy toward developing CBRN countermeasures – one that provides critical incentives for industry and a contiguous approach for research, development, acquisition, innovation, infrastructure building and stockpile maintenance. Fortunately, some of the review efforts were underway in advance of my December 1, 2009 request for an end-to-end review of medical countermeasure development across HHS.

- **What steps is the Administration taking to ensure that we are fully prepared for a bioterrorism attack, as well as continuing to stockpile medical countermeasures?**

Since 2004, BARDA has used Project BioShield to begin stockpiling and facilitating countermeasures against anthrax, smallpox, and radiation threats. Since 2007, BARDA has also utilized annual appropriations for advanced research and development (totaling over $480 million) to broaden its portfolio of CBRN countermeasures. BARDA will direct the $305 million in new funding provided by Congress in FY2010 to improve preparedness in critical threat areas, including anthrax, plague, tularemia, and radiological/nuclear.

While procuring products for the Strategic National Stockpile (SNS) can act as a deterrent to those who wish to impose terror on the American people, it does not fully ensure preparedness. To that end, BARDA, through the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE), is working with the Centers for Disease Control and Prevention as well as state and local health officials to ensure that appropriate deployment strategies are in

place to facilitate a rapid response, diminishing the adverse effects of a bioterrorist attack. BARDA also works through the PHEMCE to define and prioritize medical countermeasure requirements and to coordinate research, early and late stage product development, and procurement activities.

Please call me if you have any further thoughts or questions. I appreciate your strong commitment to public health preparedness and look forward to continuing to work with you on these important issues. A copy of this letter will also be sent to Representative Rogers who cosigned your letter.

Sincerely,

Kathleen Sebelius

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

February 3, 2010

The Honorable Michael J. Rogers
U.S. House of Representatives
Washington, D.C. 20515-0514

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Please call me if you have any further thoughts or questions. I appreciate your strong commitment to public health preparedness and look forward to continuing to work with you on these important issues. A copy of this letter will also be sent to Representative Eshoo who cosigned your letter.

Sincerely,

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

September 25, 2009

The Honorable Tom Price, M.D.
Chairman
Republican Study Committee
US House of Representatives
Washington, DC 20515

Dear Representative Price:

I am pleased that you have reached out to the Administration on behalf of the Republican Study Committee and requested a meeting to discuss health insurance reform. I look forward to sitting down with members of the RSC to discuss this critical issue.

As you also know, four of the five committees of jurisdiction have completed their work on health reform, and the Senate Finance Committee is in the process of marking up its portion of the bill this week. We are reaching a critical point in the national debate and time is of the essence.

Accordingly, I would hope that I will have the opportunity to meet with the members of the RSC within the next seven days. I will adjust my schedule in order to accommodate your availability. I understand that this is a busy time, and it is difficult to coordinate the demanding schedules of many Representatives. If the RSC membership at-large is not available to meet on or before October 2, I would be pleased to hold a meeting with a smaller group of representatives of the RSC next week.

I look forward to discussing health reform with members of the RSC. To schedule this meeting, please have your staff contact Jessica McCall at jessica.mccall@hhs.gov or 202-690-6577.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

October 26, 2009

The Honorable Robert P. Casey, Jr.
United States Senate
393 Russell Senate Office Building
Washington, DC 20510

Dear Senator Casey:

Thank you for your letter dated September 15, 2009. I enjoyed our recent opportunity to discuss a number of important topics, including the Senate Weapons of Mass Destruction Terrorism Caucus and its relationship to the Department of Health and Human Services (HHS).

The report, which you inquired about, analyzes vaccine manufacturing facility alternatives and was jointly commissioned by HHS and the Department of Defense. We are currently working closely with the National Security Staff, who originally requested the report, and with our partners in the Department of Defense to complete a final review of the report. Senior subject matter experts from the Biomedical Advanced Research and Development Authority (BARDA), which is a division within our Office of the Assistant Secretary for Preparedness and Response, will be pleased to provide you and your staff a briefing on the report when it is complete. Your office will be contacted soon to schedule the briefing.

If you have any questions or concerns in the interim, please do not hesitate to let me know. I look forward to continuing our work together.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

August 25, 2009

The Honorable Michael Enzi
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Senator Enzi:

Thank you for your recent letter regarding the importance of government transparency and accountability. I share your belief that transparency is essential to ensuring the public has confidence in their government and in the qualifications of those responsible for representing and serving them. Bringing that approach to the Department of Health and Human Services is among my highest priorities as Secretary.

With regard to your specific request, I have enclosed a list of all non-career Senior Executive Service and Schedule C appointees currently serving at the Department, including information required under 5 CFR 293.311(a) for each person/position.

Again, thank you for your letter.

Sincerely,

Kathleen Sebelius

Enclosure

Department of Health and Human Services - Political Staff January 2009 - July 2009

NAME	POSITION TITLE	ORG.	PERM APPT. TYPE	SALARY
PAS				
SEBELIUS, Kathleen	Secretary	OS	PAS-EX-1	$196,700
CORR, William	Deputy Secretary	OS	PAS-EX II	$177,000
ROUBIDEAUX, Yvette	Director, I HS	I HS	PAS-EX-V	$143,500
HAMBURG, Margaret (Peggy)	Commissioner, FDA	FDA	PAS-EX-IV	$153,000
NAZARIO, Carmen	*Hired as LT SES pending:* Assistant Secretary for Children and Families	ACF	PAS-EX-IV	$153,000
KOH, Howard	Assistant Secretary for Health	ASH	PAS-EX-IV	$153,000
LURIE, Nicole	Assistant Secretary for Preparedness and Response	ASPR	PAS-EX-IV/CC Pay	*
GREENLEE, Kathy	Assistant Secretary for Aging	AOA	PAS-IV	$153,000
NON CAREER SES				
PETROU, Laura	Chief of Staff	OS	SES - NC	$177,000
TANDEN, Neera	Senior Advisor Health Reform	OS	SES - NC	$160,000
SARVER, Justine	White House Liaison	OS	SES - NC	$140,000
BACKUS, Jenny	DAS Public Affairs (Policy and Strategy)	ASPA	SES - NC	$177,000
HUGHES, Dora	Counselor for Public Health and Science	OS	SES - NC	$145,000
ENGEL, Elizabeth	DASL (Planning and Budget)	ASL	SES - NC	$125,000
PALM, Andrea	DASL (Health Policy)	ASL	SES - NC	$130,000
BLUM, Johnathan	Director, Center for Medicare Management	CMS	SES - NC	$177,000
COHEN, Rima	Counselor for Health Policy	OS	SES - NC	$160,000
MONAHAN, John	Counselor for Human Services	OS	SES - NC	$160,000
WAKEFIELD, Mary	Administrator, HRSA	HRSA	SES - NC	$177,000
HALL, Amy	Director, Office of Legislation	CMS	SES - NC	$145,000
DIOGUARDI, Paul	Director , IGA	OS	SES - NC	$150,000
SHARFSTEIN, Josh	Principal Deputy Commissioner	FDA	SES - NC	$171,900
BLUMENTHAL, David	HIT Director	ONC	SES - NC	$177,000
CLAYPOOL, Henry	Director, Office on Disablilty	OS	SES - NC	$150,000
NINO, Maria (Teresa)	Director, External Affairs	CMS	SES - NC	$135,000
KELLEY, Alexia	Director, Center for Faith Based & Community Partnerships	CFFBCP	SES - NC	$125,000
RIVAS-VAZQUEZ, Ana Victoria	DAS for Public Affairs (Media)	ASPA	SES - NC	$144,900
MANN, Cynthia	Director, Center for Medicaid and State Operations	CMS	SES - NC	$177,000
FRIEDEN, Thomas	Director, Centers for Disease Control and Prevention	CDC	SES - NC	$177,000
TURETSKY, Vicki	Deputy Director, Office of Child Support Enforcement	ACF	SES - NC	$145,000
NEGASH, Eskinder	Director, Office of Refugee Resettlement	ACF	SES - NC	$152,000

LOMBARDI, Joan	DAS for Early Childhood	ACF	SES - NC	$166,000
HANSELL, David	DAS for Children and Families	ACF	SES - NC	$166,000
MOULDS, Donald (Don)	Principal Deputy Assistant Secretary	ASPE	SES - NC	$152,950
HOLLAND, Edward (Ned)	Assistant Secretary	ASAM	SES - NC	$177,000
SMALLS, Dawn	Executive Secretary	Exec Sec	SES - NC	$140,000
SCHEDULE C				
LAMBREW, Jeanne	Director, HHS Office of Health Reform	Health Reform	Schedule C	$153,200
CANNISTRA, Jennifer	Special Assistant	Health Reform	Schedule C	$92,723
LAPAN, Jarel	Special Assistant to the Deputy Secretary	DS	Schedule C	$86,927
FILIPIC, Anne	Deputy White House Liaison	OS/WHL	Schedule C	$86,927
HSU, Irene	Confidential Assistant	OS/WHL	Schedule C	$73,100
ADELMAN, Rebecca	Confidential Assistant to the ASPA	ASPA	Schedule C	$60,989
GRANHOLM, Timothy	Confidental Assistant to the ASPA	ASPA	Schedule C	$41,210
SESHAMANI, Meena	Special Assistant	Health Reform	Schedule C	$102,721
KIDWELL, Lauren	Confidential Assistant	ASL	Schedule C	$73,100
PAPAS, Nicholas	Special Assistant	ASPA	Schedule C	$86,927
TAYLOR, Bridgett	Special Assistant	ASL	Schedule C	$153,053
MITCHELL, Samuel	Special Assistant	OS	Schedule C	$86,927
McCALL, Jessica	Confidential Assistant	OS	Schedule C	$73,100
CITRON, Jamison	Confidential Assistant	CFBCP	Schedule C	$60,989
SHAPIRO, Jonathan	Confidential Assistant	ASPE	Schedule C	$73,100
WOLFF,Kathryn	Special Assistant	IGA	Schedule C	$86,927
SUVOR, Daniel	Confidential Assistant	OGC	Schedule C	$60,989
FITZGERALD, Erin	Confidential Assistant	ASL	Schedule C	$60,989
MOORE, Jesse	Confidential Assistant	ACF	Schedule C	$60,989
VANDERSLICE,Mara	Special Assistant	CFBCP	Schedule C	$86,927
WEEDEN, C'Reda	Special Assistant	OS	Schedule C	$86,927
DOUGLAS, Linda	Director of Communications Office of Health Reform	Health Reform	Schedule C	$153,200
PARISI, Julie	Special Assistant	Scheduling & Adv	Schedule C	$41,210
HASH, Michael	Special Assistant	Health Reform	Schedule C	$153,200
RICHARDSON, Karen	Special Assistant	Health Reform	Schedule C	$86,927
SPRINGFIELD, Aprill	Special Assistant	IOS	Schedule C	$120,830
KELLEY, Jeffrey	Director, Office of Public Affairs	ACF	Schedule C	$153,200
HALLE, Michael	Confidential Assistant	Health Reform	Schedule C	$60,989
SMITH, Barbara	Special Assistant	Health Reform	Schedule C	$120,830
LEWIS, Caya	Special Assistant	Health Reform	Schedule C	$120,830
NOWINSKI, Juliegh	Confidential Assistant to the ASH	ASH/OPHS	Schedule C	$73,100

DAVIS, Damon	Special Assistant to the National Coordinator	ONC	Schedule C	$120,830
RUDISILL, Shannon	Associate Commissioner	ACF	Schedule C	$140,969
BARSON, Emily	Director of Scheduling and Advance	Scheduling & Adv	Schedule C	$86,927
YU, Wilbur	Special Assistant to the National Coordinator	ONC	Schedule C	$120,830
DROBAC, Krista	Special Assistant to the Director, Office of Legislation	CMS	Schedule C	$120,830
TEATER, Louis (Ducan)	Confidential Assistant (Advance)	IOS	Schedule C	$60,989
SIMON, Michael	Regulations Analysis Officer	Exec Sec	Schedule C	$86,927
JACKSON, Nathaniel	Senior Speechwriter	ASPA	Schedule C	$86,927
MORALES, Esther	Special Assistant to the DAS Early Childhood	ACF	Schedule C	$86,927
HALLBERG, Berit	Confidential Assistant	ASPA	Schedule C	$41,210

ACF: Administration for Children and Families
AOA: Administration on Aging
ASAM: Assistant Secretary for Administration and Management
ASH: Assistant Secretary for Health
ASL: Assistant Secretary for Legislation
ASPA: Assistant Secretary for Public Affairs
ASPE: Assistant Secretary for Planning and Evaluation
ASPR: Assistant Secretary for Preparedness and Response
ASRT: Assistant Secretary for Resources and Technology
CDC: Centers for Disease Control & Prevention
CFBCP: Center for Faith Based Community Partnerships
CMS: Centers for Medicare & Medicaid Services
DS: Office of the Deputy Secretary
Exec Sec: Executive Secretariat
FDA: Food and Drug Administration
HRSA: Health Resources & Services Administration
IGA: Intergovernmental Affairs
I HS: Indian Health Service
IOS: Immediate Office of the Secretary
OD: Office on Disability
OGC: Office of General Counsel
ONC: Office of the National Coordinator for Health Information Technology
OPHS: Office of Public Health and Science
OS: Office of the Secretary
WHL: White House Liaison

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 15 2009

The Honorable Michael B. Enzi
United States Senate
Washington, DC 20510

Dear Senator Enzi:

Thank you for your letter dated June 10 requesting my views on the Affordable Health Choices Act. Before responding, I want to thank you for your efforts to date to advance health reform legislation. The Health, Education, Labor and Pensions Committee (HELP) has, over the last year, held numerous hearings and roundtables on health reform, ensuring that all voices and views are heard. Its members have held these hearings and worked on the policy in the spirit of putting partisanship aside given the critical nature of the task. And the task is crucial: skyrocketing costs are bankrupting families, businesses, and the government. The time to act is now.

The Department of Health and Human Services (HHS) has been, and will continue to be, an active participant in this debate. As the lead agency and largest purchaser of health care in the nation, HHS has the knowledge and experience to inform efforts to fix what is broken about the health system. Our newly created Office of Health Reform coordinates efforts across the Department to support the development of legislation to improve health care affordability, access, and choices. In addition, HHS staff has continued the tradition of providing technical assistance at the request of Members of Congress on their ideas and proposals. This technical assistance includes input such as legal help with drafting and data on existing programs, but it stops short of conveying Administration policy or position. On health reform, our policy comes from the President.

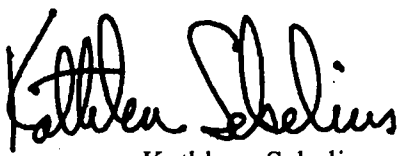
The President wrote a letter last week to convey his guidance on health reform legislation. He reiterated his core belief that Americans should have better choices for health insurance, building on the principle that if they like the coverage they have now, they can keep it, while seeing their costs lowered as our reforms take hold. He stressed the imperative of fixing what is broken in a fiscally responsible way. Just last Saturday, the President offered additional ideas on how to reduce Federal health spending to help Congress achieve this goal as well. He expressed his openness to ideas on shared responsibility in the health system, with exceptions made for individuals and small businesses who cannot afford health care. And, he called for the creation of a health insurance exchange – a market where Americans can one-stop shop for a health care plan, choosing the plan that's best for them. This market should include the choice of a public health insurance option operating alongside private plans. This will give them a better range of choices, make the health care market more competitive, and keep insurance companies honest.

The Affordable Health Choices Act, in its draft form, generally adheres to the President's principles. It ends the denial of coverage based on pre-existing conditions and creates new choices through insurance "gateways." These gateways allow people to compare benefits and prices, and choose the plan that best suits their need, including a public health insurance option. It improves affordability and quality, prioritizes prevention, and invests in the health care workforce to meet our 21st-century needs. We look forward to reviewing its complete form as well as the version of the legislation that includes the policies in the Finance Committee jurisdiction that can supplement your Committee's efforts to slow growth in health costs and finance reform. Even in its draft form, the Affordable Health Choices Act represents a major step toward our shared goal of quality, affordable care for all Americans.

Your letter expresses a concern that there has been no official, written HHS input on this bill. Traditionally, the Administration offers written policy statements later in the legislative process, through agency bill reports and testimony or OMB statements of Administration position. The Administration has furnished some technical assistance on the bill from a drafting standpoint to the Committee staff. My staff is willing to meet with your staff as well to respond to any technical questions you might have on any aspect of the bill in its current form.

Thank you again for your continued commitment to health reform.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 15 2009

The Honorable Orrin G. Hatch
United States Senate
Washington, DC 20510

Dear Senator Hatch:

Thank you for your letter dated June 10 requesting my views on the Affordable Health Choices Act. Before responding, I want to thank you for your efforts to date to advance health reform legislation. The Health, Education, Labor and Pensions Committee (HELP) has, over the last year, held numerous hearings and roundtables on health reform, ensuring that all voices and views are heard. Its members have held these hearings and worked on the policy in the spirit of putting partisanship aside given the critical nature of the task. And the task is crucial: skyrocketing costs are bankrupting families, businesses, and the government. The time to act is now.

The Department of Health and Human Services (HHS) has been, and will continue to be, an active participant in this debate. As the lead agency and largest purchaser of health care in the nation, HHS has the knowledge and experience to inform efforts to fix what is broken about the health system. Our newly created Office of Health Reform coordinates efforts across the Department to support the development of legislation to improve health care affordability, access, and choices. In addition, HHS staff has continued the tradition of providing technical assistance at the request of Members of Congress on their ideas and proposals. This technical assistance includes input such as legal help with drafting and data on existing programs, but it stops short of conveying Administration policy or position. On health reform, our policy comes from the President.

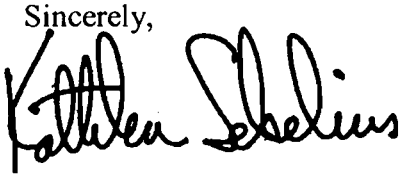
The President wrote a letter last week to convey his guidance on health reform legislation. He reiterated his core belief that Americans should have better choices for health insurance, building on the principle that if they like the coverage they have now, they can keep it, while seeing their costs lowered as our reforms take hold. He stressed the imperative of fixing what is broken in a fiscally responsible way. Just last Saturday, the President offered additional ideas on how to reduce Federal health spending to help Congress achieve this goal as well. He expressed his openness to ideas on shared responsibility in the health system, with exceptions made for individuals and small businesses who cannot afford health care. And, he called for the creation of a health insurance exchange – a market where Americans can one-stop shop for a health care plan, choosing the plan that's best for them. This market should include the choice of a public health insurance option operating alongside private plans. This will give them a better range of choices, make the health care market more competitive, and keep insurance companies honest.

The Affordable Health Choices Act, in its draft form, generally adheres to the President's principles. It ends the denial of coverage based on pre-existing conditions and creates new choices through insurance "gateways." These gateways allow people to compare benefits and prices, and choose the plan that best suits their need, including a public health insurance option. It improves affordability and quality, prioritizes prevention, and invests in the health care workforce to meet our 21st-century needs. We look forward to reviewing its complete form as well as the version of the legislation that includes the policies in the Finance Committee jurisdiction that can supplement your Committee's efforts to slow growth in health costs and finance reform. Even in its draft form, the Affordable Health Choices Act represents a major step toward our shared goal of quality, affordable care for all Americans.

Your letter expresses a concern that there has been no official, written HHS input on this bill. Traditionally, the Administration offers written policy statements later in the legislative process, through agency bill reports and testimony or OMB statements of Administration position. The Administration has furnished some technical assistance on the bill from a drafting standpoint to the Committee staff. My staff is willing to meet with your staff as well to respond to any technical questions you might have on any aspect of the bill in its current form.

Thank you again for your continued commitment to health reform.

Sincerely,



Kathleen Sebelius

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 16 2009

The Honorable Nydia Velazquez
House of Representatives
2361 Rayburn House Office Building
Washington, D.C. 20515

Dear Ms. Velazquez:

Thank you for your letter regarding proposed rule CMS-0013-P, "HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS."

As you know, the public comment period for CMS-0013-P closed on October 21, 2008. We received over 3,000 comments from industry and interested stakeholders, and CMS is carefully considering all comments received, including many comments regarding the proposed ICD-10 implementation timeline, as it works towards the development of an ICD-10 final rule.

I appreciate you sharing your views on this important effort. Please call me if you have any further questions or concerns.

Sincerely,

Michael O. Leavitt